BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0001 Registered No. 362 922 67 0001

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARCHUK FRANK

2. DATE AND HOUR OF DEATH: 1/1/67 4:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 5413 KNELL AVENUE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	2/25/91	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
STEELWORKER	STEEL Mfg.	RUSSIA	U.S.A.

13. FATHER'S NAME: Marchuk

14. MOTHER'S MAIDEN NAME: Anna Sorenan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	213-07-8799	Mary M. Marchuk	5413 Knell Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS
DUE TO
(B) ATHEROSCLEROTIC HEART DISEASE
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: RIGHT LOWER LOBE PNEUMONIA

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 9 1966 to January 1 1967, that (I) (we) last saw the deceased alive on January 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David Seff M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): DAVID SEFF M.D.

23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1-5-67	MT. OLIVET	BALTIMORE, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 8 1967	[illegible]	Geo. L. Schwab Funeral Home	2101 Frederick Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be [illegible]ved by the chief medical examiner or his assistant if death [illegible]red in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-45 1

BIRTH NO. 67 0002

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0002

1. NAME OF DECEASED (Type or Print): CLANCY, JOSEPH THOMAS

2. DATE AND HOUR OF DEATH: 1 JAN 67 | 5 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEM. HOSP.

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-01
D. STREET ADDRESS (If rural, give location): 980 NORTH HILL Rd

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 07-08-18 ~~01-01~~
9. AGE (In years last birthday): 48
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): C.P.A.
10B. KIND OF BUSINESS OR INDUSTRY: James M. Fincham & Co. ~~xxxxx~~
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS CLANCY
14. MOTHER'S MAIDEN NAME: JOSEPHINE BAUERSFELD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) yes ~~xxxxxx~~ (If yes, give war or dates of service) WW2
16. SOCIAL SECURITY NO. 215-14-5078
17. INFORMANT: Mrs. M. Geraldine Clancy
ADDRESS: 980 North Hill Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

420.1

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1-JAN 1967 to 1-JAN 1967, that ~~(I)~~ (we) last saw the deceased alive on 1-JAN 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1 Jan 67
23C. PHYSICIAN'S NAME (Type): SIDNEY E. KIRKLEY M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/'67
24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 2 1967
25B. NAME OF REGISTRAR: Charles E. Lankford M.D.
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 0003

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0003

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Catherine Holdorf

2. DATE AND HOUR OF DEATH: Jan. 1, 1967 2:30 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1938 Midland Rd

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 12/16/02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Louis Espey
14. MOTHER'S MAIDEN NAME: Mary Phiffer
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-22-8020
17. INFORMANT: Mary C. MacNeal (daughter)
ADDRESS: same.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 1B. 420.1 — 200.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 weeks

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malignant Lymphoma + skin, pulmonary, bone + lung metastases — 2 years

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 15 1966 to Jan 1 1967, that (I) (we) last saw the deceased alive on Jan. 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Goodall M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/1/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Maryland General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/'67
24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 2 1967
25B. NAME OF REGISTRAR: Robert E. [illegible]
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

47-95-48TN

BIRTH NO. U-462 67 0004

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0004

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Emma Ulrich

2. DATE AND HOUR OF DEATH: 1-1-67 | 1:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE Balto

D. STREET ADDRESS (If rural, give location): 38 SEAFORD AVENUE 33-00

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 9-23-75

9. AGE (In years last birthday): 91

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. JOHN Rodgers

14. MOTHER'S MAIDEN NAME: AMELIA Shaney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. J1 216-54-1176

17. INFORMANT: RECORDS-BCH

ADDRESS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) [redacted] — INTERVAL BETWEEN ONSET AND DEATH: [redacted]

DUE TO

(B) Arteriosclerosis generalized — 10 yrs

DUE TO

(C) Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-20-66 1966 to 1-1 1967, that (I) (we) last saw the deceased alive on 1-1- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard G. Bishop M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-1-67

23C. PHYSICIAN'S NAME (Type): DR. RICHARD G. BISHOP M.D.

23D. ADDRESS: 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-4-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county): Baltimore (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

25B. NAME OF REGISTRAR: R. L. E. Barbagallo

25C. FUNERAL DIRECTOR: Lassahn Funeral Home

ADDRESS: 36 7401 Belair Road

VS 150-REV. 1/1/65

1

P-525

67 0005

BALTIMORE CITY HEALTH DEPARTMENT

67 0005

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CALEB PINKINE

2. DATE AND HOUR PRONOUNCED DEAD: January 1, 1967 5:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-05

D. STREET ADDRESS (If rural, give location): 4004 Pennington Avenue

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH:

9. AGE (In years last birthday): 71

If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10B. KIND OF BUSINESS OR INDUSTRY: Olin-Mathison

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Emmitt Pinkine

14. MOTHER'S MAIDEN NAME: Lillie Mae Hubbard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family ADDRESS: Same

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/2/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/4/67

23C. NAME of CEMETERY or CREMATORY: Loudon Park Cem

23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: McCully F H 237 Patapsco Ave ADDRESS: 21225

0 0 0 4

VS 151-REV. 1/1/65

B-216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0006 Registered No. 67 0006

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BIRD H. BISHOP

2. DATE AND HOUR OF DEATH: 1-1-67 12.30A.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-07
D. STREET ADDRESS (If rural, give location): 625 W. UNIVERSITY PARKWAY

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	MARRIED	10-20-20	46		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lawyer	Gas & Electric	Md.	USA

13. FATHER'S NAME: CHARLES B. BISHOP

14. MOTHER'S MAIDEN NAME: JENNIE HYDE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW 11	597-38-6735	Mrs. Harriett C. Bishop	Above

MEDICAL CERTIFICATION

18. 142.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) SEPTICEMIA - PNEUMONIA.	4 days.
DUE TO (B) AGRANULOCYTOSIS	?
DUE TO (C) CARCINOMA OF PAROTID GLAND - DISSEMINATED	

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-28 19 66 to 1-1 19 67, that (I) (we) last saw the deceased alive on 1-1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Carlton R. Hamilton Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-1-67.

23C. PHYSICIAN'S NAME (Type): C.R.HAMILTON,JR. M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-4-67	Druid Ridge	Pikesville	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 3 1967	[illegible]	H.W. Jenkins & Sons Co.	4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 1522 67 0007

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0007

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released by

1. NAME OF DECEASED (Type or Print): JANKIEWICZ JOHN

2. DATE AND HOUR OF DEATH: 1-1-67 8:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL BALTIMORE, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 907 S. BELMORD AVE 21224

1-04

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: AUG 20, 1889
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED BALTIMORE CITY SANITATION DEPT.
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANK JANKIEWICZ
14. MOTHER'S MAIDEN NAME: ANTIONETTE ZYZKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-40-4960
17. INFORMANT: ALEXANDORA JANKIEWICZ
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.0 I 260 X
(A) Arteriosclerotic Heart Disease — yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — yrs

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 1-1- 1967 to 1-1 1967, that (I) (we) last saw the deceased alive on 1-1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: I.C. Mariano M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-1-67
23C. PHYSICIAN'S NAME (Type): I.C. MARIANO M.D.
23D. ADDRESS: CHURCH HOME & HOSPITAL BALTIMORE, Md. 21

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN 5-67
24C. NAME of CEMETERY or CREMATORY: ST. STANISLAUS
24D. LOCATION (City, town, or county) (State): 6515 BOSTON ST.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: MARIE FALKOWSKI
ADDRESS: 1000 S. KENWOOD AVE.

VS 150-REV. 1/1/65

T-520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0008 Registered No. 67 0008

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Thomas, Leroy

2. DATE AND HOUR OF DEATH: 1-1-67 | 6.10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 704
D. STREET ADDRESS (If rural, give location): 1645 ABBOTT STREET 21202

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 2-13-15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: MELVINA WILLIAMS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 221-12-1499
17. INFORMANT: Odessa Thomas ADDRESS: 1645 Abbott St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): 199.2 Carcinomatosis.

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH: years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from Jan 1 1967 to Jan 1 1967, that (I) (we) last saw the deceased alive on 6:45 PM Jan 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Tah-Hsing Hsu M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): TAH-HSIUNG HSU M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/5/67
24C. NAME of CEMETERY or CREMATORY: Carver Mem. Pk
24D. LOCATION (City, town, or county) (State): Laurel, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Joseph G. Rocks Jr.
ADDRESS: 1304 N. Carroll St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

T-162

67 0009

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0009

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VICTOR TOPORZYCKI

2. DATE AND HOUR PRONOUNCED DEAD: January 2, 1967 6:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Home & Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

2-02

D. STREET ADDRESS (If rural, give location): 23 S. Broadway

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: March 18, 1893

9. AGE (In years last birthday): 73

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Watchman

10B. KIND OF BUSINESS OR INDUSTRY: Can Co.

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Toporzycki

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-16-5042

17. INFORMANT: John V. Toporzycki Sr. ADDRESS: 215 S. Highland Ave.

MEDICAL CERTIFICATION

1B. 4221

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/2/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-6-1967

23C. NAME of CEMETERY or CREMATORY: New Cathedral

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 1901-07 Eastern Ave.

VS 151-REV. 1/1/65

1

B-526

BIRTH NO. 67 0010

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0010

1. NAME OF DECEASED (Type or Print): WILLIAM BUNGER

2. DATE AND HOUR PRONOUNCED DEAD: January 1, 1967 11:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2418 Foster Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

1-03

D. STREET ADDRESS (If rural, give location): 2418 Foster Avenue

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced) (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Single	June 14, 1909	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bottle Dept.	National Brewery	Baltimore, Maryland	

13. FATHER'S NAME: Henry Bunger

14. MOTHER'S MAIDEN NAME: Anna Clemens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	5-6-41 5-12-45	215-10-1027	Mrs. Margaret McClelland	2418 Foster Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

4221

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

DATE SIGNED: 1/2/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-5-1967	Baltimore National	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 3 1967	[signature]	Lilly & Zeller Inc.	1901-07 Eastern Ave.

VS 151-REV. 1/1/65

T460

BIRTH NO. 67 0011

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0011

1. NAME OF DECEASED (Type or Print): Taylor, Joseph D

2. DATE AND HOUR OF DEATH: Jan. 1, 1967 | 4 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: 13-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2252 W. MADISON AVE.

5. SEX: MALE

6. RACE: NEGROID

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10-02-04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT TAYLOR

14. MOTHER'S MAIDEN NAME: FLORENCE JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No.

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-6747

17. INFORMANT: Mrs. Lucille Taylor

ADDRESS: 2252 Madison Ave Apt 2

MEDICAL CERTIFICATION

1B. 4518

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Abd. Aortic Aneurysm

DUE TO

(B) Arteriosclerotic Vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/31/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Abd. Aortic Aneurysm

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 12/30/66 19 to 1/1/67 19, that I (we) last saw the deceased alive on 1/1/67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: H.R. Gertner, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): H.R. GERTNER, JR. M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-5-67

24C. NAME of CEMETERY or CREMATORY: Pleasant Rest Cem.

24D. LOCATION (City, town, or county): Towson (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Morton C. Dyer F.H.

ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

122 73 33

M 200 1

BIRTH NO. 67 0012

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0012

1. NAME OF DECEASED (Type or Print): MACKAY RICHARD

2. DATE AND HOUR OF DEATH: 2 JAN. 67 | 3 55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTIMORE 11-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 306 WEST FRANKLIN ST.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 02-08-90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Customs
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. MACKAY
14. MOTHER'S MAIDEN NAME: Hannah Elizabeth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 213-34-4646
17. INFORMANT: MR. JAMES FIELDS
ADDRESS: 478 BONNIE BRAE TOWSON, MD

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 527.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

(B) Emphysema

DUE TO

(C) ASCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 31 Dec 1966 to 2 JAN 1967, that (I) (we) last saw the deceased alive on 2 JAN 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sidney E. Kirkley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 2 Jan 67
23C. PHYSICIAN'S NAME (Type): SIDNEY E. KIRKLEY M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Buried
24B. DATE: Jan. 5, 1967
24C. NAME of CEMETERY or CREMATORY: Trenton Cemetery
24D. LOCATION (City, town, or county) (State): Trenton Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: John E. Goff
ADDRESS: Hampstead, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P. 456

1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0013

Registered No. 67 0013

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PALMER, JOHN HENRY

2. DATE AND HOUR OF DEATH: 1/2/67 12 Noon | 12 0 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 402

D. STREET ADDRESS (If rural, give location): 221 N Fremont Ave.

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5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	MARRIED	2/28/99	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
UNEMPLOYED	N/A	MARYLAND	U.S.A.

13. FATHER'S NAME: LOUIS PALMER

14. MOTHER'S MAIDEN NAME: LILLIE SPENCE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
UNK.	UNK.	UNK.	WIFE	

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Arteriosclerotic Cardiovascular disease & left middle cerebral artery thrombosis — 5 days

DUE TO

(B) Cerebral artery thrombosis — 5 days

DUE TO

(C) Pneumonia — 3 days

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Suspected myocardial infarct

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None	None	Yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
No.	N/A	N/A

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
N/A	While At Work ☐ Not While At Work ☐	N/A

22. I certify that (I) (this hospital) attended the deceased from 12/27/66 19 to 1/2 19 67, that (I) (we) last saw the deceased alive on 1/2/67 19 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Bernard S. Karsean Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/2/67

23C. PHYSICIAN'S NAME (Type): BERNARD S. KARSEAN JR. M.D.

23D. ADDRESS: University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/67	Mt Auburn	Baltimore

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 3 1967	Robert E. Fenton	Thomas P. Hayes	338 N Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 0014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0014

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Witkowski (TRAWINSKI) ARCENIA PAULINE

2. DATE AND HOUR OF DEATH: 1-1-1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital 100 N. Broadway Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 1-03

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 709 Lakewood Ave.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 1-9-04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: MARTIN TRAWINSKI

14. MOTHER'S MAIDEN NAME: ANNA SUMOR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: WALTER WITKOWSKI (Hus) ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia

DUE TO

(B) Agranulocytosis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes mellitus
Arteriosclerotic Cardiovascular Disease

Yrs.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/23 1966 to 1/1 1967, that (I) (we) last saw the deceased alive on 1/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Francisco Baltazar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR M.D.

23D. ADDRESS: CHURCH HOME & HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-5-67

24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEMETERY

24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

25B. NAME OF REGISTRAR: Robert E. Fallon

25C. FUNERAL DIRECTOR: JOHN M. WEBER & SONS INC.

ADDRESS: 401 S. CHESTER ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-65

BIRTH NO. 67 0015

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0015

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Robert M. Brown

2. DATE AND HOUR OF DEATH: 1/1/67 12:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 5300
D. STREET ADDRESS (If rural, give location): 7508 Knollwood Rd.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 04/01/01
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Japan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles L. Brown
14. MOTHER'S MAIDEN NAME: Va. Frantz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records
ADDRESS

MEDICAL CERTIFICATION

18. 161X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 12/30 1966 to 1/1 1967, that ~~(I)~~ (we) last saw the deceased alive on 1/1 1967 and that ~~I (my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Bernard du Buy M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): Bernard du Buy M.D.
23D. ADDRESS: Md. Genl. Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-4-67
24C. NAME of CEMETERY or CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Baltimore, Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson, Towson, Md.
ADDRESS

VS 150-REV. 1/1/65

1
M-625

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0016 Registered No. 67 0016

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HENRY W. MORGAN

2. DATE AND HOUR PRONOUNCED DEAD: January 1, 1967 2:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4403 Asbury Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4403 Asbury Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	Never Married	Sept. 26, 1909	57	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sect y Treas.	Christian Home	Pennsylvania	U.S.A.

13. FATHER'S NAME: Taliesin W. Morgan

14. MOTHER'S MAIDEN NAME: Mary Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Donald Johnson Funeral Home, Hudson, Ohio ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

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I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage

DUE TO

(B) Blunt Head Injury

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute and Chronic Alcoholism

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 4403 Asbury Avenue 26-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): about 12 31 '66 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Apparently Fell Down Steps.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/2/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Jan. 4, 1967

23C. NAME of CEMETERY or CREMATORY: Crown Hill Cemetery

23D. LOCATION (City, town, or county) (State): Summit Co., Ohio

24A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

24B. NAME OF REGISTRAR: C. E. Fahey

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc. ADDRESS: 1217 St. Paul St. Baltimore, Maryland

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VS 151-REV. 1/1/65

B-63 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0017 Registered No. 67 0017

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FLORENCE R. BARTELL

2. DATE AND HOUR OF DEATH: January 2, 1967. 12 10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Long Green Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #18 12-01

D. STREET ADDRESS (If rural, give location): 3959 Cloverhill Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: March 25, 1877.

9. AGE (In years last birthday): 89

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry D. Koethe

14. MOTHER'S MAIDEN NAME: Emma L. Bender

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 217-54-8300

17. INFORMANT: Mr. George E. Bartell ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Congestive Heart Failure

DUE TO Cerebro-Vascular Disease

(B) Hypertrophic Cardiomyopathy

DUE TO Senile - Sclerosis

(C)

INTERVAL BETWEEN ONSET AND DEATH

6-12 hrs

2-4 months

Gradual onset

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 1940 to Jan 2 1966, that (I) (we) last saw the deceased alive on Jan 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W H Woody M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-3-66

23C. PHYSICIAN'S NAME (Type): W. H. Woody, M. D.

23D. ADDRESS: 1403 Park Ave Balti Md 21217

24A. BURIAL CREMATION, REMOVAL (Specify): Entombment

24B. DATE: 1/5/67.

24C. NAME of CEMETERY or CREMATORY: Lorraine Mausoleum

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 3 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR: Leonard J. Rack, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0018 Registered No. 67 0018

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lerou Starr

2. DATE AND HOUR OF DEATH: Jan. 2, 1967 | 3:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #6

D. STREET ADDRESS (If rural, give location): 5623 Walther ~~Street~~ Ave.

27-34

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	married	Dec. 19, 1919.	47		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Assoc. Engineer		Virginia	USA

13. FATHER'S NAME: Roy Starr

14. MOTHER'S MAIDEN NAME: Virginia Pugh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	WW 2	216-01-9436	Anna Starr	same

MEDICAL CERTIFICATION

18. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — 1 yr.

DUE TO

(B) A.S.H.D.

DUE TO

(C) Hypertension, essential — 10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 1965 to Jan 2 1967, that (I) (we) last saw the deceased alive on 12-22- 1966 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/3/67.

23C. PHYSICIAN'S NAME (Type): K.A. Peter van Berkum M.D.

23D. ADDRESS: 100 W. University Pkwy., Balto. Md. 21210

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/67.

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc

ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-30b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0019 Registered No. 67 0019

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Kenneth A. Booth, Sr.

2. DATE AND HOUR OF DEATH: 1/1/1967 3:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore. 8-01
D. STREET ADDRESS (If rural, give location): 3410 Woodstock Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male.	White.	Married.	6/23/1913	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supervisor.	Laundry.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Albert Booth.

14. MOTHER'S MAIDEN NAME: Nora ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-7772

17. INFORMANT: Doris V. Booth. ADDRESS: 3410 Woodstock Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Acute myocardial infarction	minutes
DUE TO (B)	Arteriosclerotic heart disease with angina	4 yrs
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/4/62 19 to 12/21/66 19, that (I) (we) last saw the deceased alive on 12/21/ 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/3/67

23C. PHYSICIAN'S NAME (Type): Dr. M. Friedman M.D.

23D. ADDRESS: 5211 Harford Rd.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/1967

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Leonard J. Ruck, inc. ADDRESS: 5305 Harford Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-60b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0020 Registered No. 67 0020

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Murray, Agnes R. Dorsey

2. DATE AND HOUR OF DEATH: 1/1/67 8:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital (Accident Room)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 3004 - Pressman St.

16-07

46

5. SEX: Fe 6. RACE: Negroe 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed 8. DATE OF BIRTH: 2/4/13 9. AGE (In years last birthday): 53 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salard Girl 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Maryland 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James T. Dorsey 14. MOTHER'S MAIDEN NAME: Kattie Holley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 214-22-9062 17. INFORMANT: Walter Dorsey ADDRESS: 4424 Finney Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4201

(A) Acute Myocardial Infarction

DUE TO

(B) hypertensive Arteriosclerotic Cardiovascular

DUE TO

(C) Disease

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 22 19 66 to December 16 19 66, that (I) (we) last saw the deceased alive on December 16, 19 66 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert C Blackmon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): Robert C. Blackmon M.D. 23D. ADDRESS: Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1/5/67 24C. NAME of CEMETERY or CREMATORY: Balto National Cem 24D. LOCATION (City, town, or county) (State): Balto Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 3 1967 25B. NAME OF REGISTRAR: Robert E. Tolley M.D. 25C. FUNERAL DIRECTOR: Wm MARSH ADDRESS: 928 E. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0021 Registered No. 67 0021

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bessie Kroeger

2. DATE AND HOUR OF DEATH: Jan 1, 1967 | 3:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1105 E. Fayette Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 763 W. Cross St. 2 Balto.

D. STREET ADDRESS (If rural, give location): See Above 763 W. Cross St.

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): 8. DATE OF BIRTH: 8-9-94 9. AGE (In years last birthday): 72 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife. 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Unknown. 12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Reed 14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No. (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: 17. INFORMANT: George Alley ADDRESS: 502 Old Riverside Rd

MEDICAL CERTIFICATION

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO: Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

(B) DUE TO: ASCVD — 5 or 6 yrs.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Chronic obstructive Lung Dis — 28 yrs.

19A. DATE OF OPERATION: 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐: 21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (~~this person~~) attended the deceased from 10-17 1966 to JAN 1, 1967, that (I) (~~we~~) last saw the deceased alive on 12-31 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐ 23B. DATE SIGNED: Jan 1, 1967

23C. PHYSICIAN'S NAME (Type): E. Ellsworth Cook M.D. 23D. ADDRESS: 2431 Maryland Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1-4-67 24C. NAME OF CEMETERY or CREMATORY: Glen Haven Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967 25B. NAME OF REGISTRAR: R. C. E. Bailey M.D. 25C. FUNERAL DIRECTOR: Walter Dabrowski ADDRESS: 1005 Dundalk Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-42-24 IP G-615

BIRTH NO. 67 0022

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0022

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARY HARDIN GRIFFNER

2. DATE AND HOUR OF DEATH: 1-2-67 10 45 P.M.

CERTIFICATE AMENDED 2-3-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: X
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-36
D. STREET ADDRESS (If rural, give location): 1415 CURIE WAY 21224

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: Sept. 28, 1910 ~~9-27-10~~
9. AGE (In years last birthday): 56
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Novak NOJEK
14. MOTHER'S MAIDEN NAME: Alexanda Lupinski RUPINSKA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: #21224 RECORDS-BCH-4940 EASTERN AVENUE
ADDRESS:

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

1B. 120X

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A)	RESPIRATORY INSUFFICIENCY	~2 hrs
DUE TO	? AIRWAY OBSTRUCTION	
(B)	? CARCINOMATOSIS	3 mos.
DUE TO	? CHF	
(C)	SCIRRHOUS CA OF (R) BREAST	?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8 30 pm 1-2 1967 to 10 45 pm 1-2 1967, that (I) (we) last saw the deceased alive on 1-2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Daniel C. Hadlock M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-2-67

23C. PHYSICIAN'S NAME (Type): DR. DANIEL C. HADLOCK M.D.
23D. ADDRESS: BCH-4940 EASTERN AVENUE-BALTIMORE, MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: Nicholas E. Calamia
25C. FUNERAL DIRECTOR: Walter Dabrowski
ADDRESS: 1005 Dundalk Ave.

VS 150-REV. 1/1/65

Corrected by Birth Certificate A-60167 -
for Mary Nojek 2-3-67 M.H.

C-52d

BIRTH NO. 67 0023

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0023

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ANNA CHIMIAK

2. DATE AND HOUR OF DEATH: JAN. 2, 1967 1:42 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HARFORD GARDENS CONVELECENT HOME, 4700 HARFORD RD.

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: 21213
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 26-03
D. STREET ADDRESS (If rural, give location): 3015 SHANNON DR.

5. SEX: FEMALE
6. RACE: WHITE.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: JUL. 15, 97
9. AGE (In years last birthday): 69 — If Under 1 Yr. Months / Days; If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE.
10B. KIND OF BUSINESS OR INDUSTRY: HOME.
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL BAROWSKI
14. MOTHER'S MAIDEN NAME: CATHERINE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-22-6127
17. INFORMANT: ANTHONY CHIMIAK — ADDRESS: 3015 SHANNON DR. BALTO. MD.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 203X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — 2 days

DUE TO

(B) Multiple Myeloma

DUE TO

(C) Pathological Fracture Left Femur

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Secondary anemia severe

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 18 1966 to Jan 2 1967, that (I) (we) last saw the deceased alive on Jan 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter A Anderson M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-5-67
24C. NAME of CEMETERY or CREMATORY: HOLY CROSS CEM.
24D. LOCATION (City, town, or county) (State): ANNE ARUNDEL CO. MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: W. Faikowski — ADDRESS: 2007 Eastern Ave. Balto. Md. 21231

VS 150-REV. 1/1/65

47-19-76 IB D-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0024 Registered No. 67 0024

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DRUMMOND CORNELIA Ora

2. DATE AND HOUR OF DEATH: 1/2/67 | 9 15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-09

D. STREET ADDRESS (If rural, give location): 1708 HOLBROOK STREET #21202

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 8-22-90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS JOHNSON

14. MOTHER'S MAIDEN NAME: ELLA ROCHELLE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: #21224 RECORDS-BCH-4940 EASTERN AVENUE

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 493X

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD c̄ multiple CVA's

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/23 19 66 to 1/2 19 67, that ~~(I)~~ (we) last saw the deceased alive on 1/2 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: James T. Corkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/2/67

23C. PHYSICIAN'S NAME (Type): DR. JAMES T. CORKINS M.D.

23D. ADDRESS: #21224 BCH-4940 EASTERN AVENUE-BALTIMORE, MD

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 6 /67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem

24D. LOCATION (City, town, or county) (State): Westport Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Goslin T. Erickson

ADDRESS: 1129 N. Caroline St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-430 1

BIRTH NO. 67 0025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0025

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BETTY J. YELITY

2. DATE AND HOUR OF DEATH: Jan 1-67 | 12:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital 100 N. Broadway Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 6-05

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 14 N. Bond St. (31)

5. SEX: F

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 10-18-21

9. AGE (In years last birthday): 45

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. C.

12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: EUGENE GUNDY

14. MOTHER'S MAIDEN NAME: OLIVIA GUNDY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family ADDRESS:

MEDICAL CERTIFICATION

1B. 260X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Anterior Myocardial Ischemia — days

DUE TO

(B) Septicemia

DUE TO

(C) Diabetes mellitus with Acidosis — years, days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-28 1966 to 1-1- 1967, that (I) (we) last saw the deceased alive on 1-1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N. Penaflor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-1-67

23C. PHYSICIAN'S NAME (Type): NORMA PENAFLOR M.D.

23D. ADDRESS: Church Home & Hospital Balto. Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 5/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem

24D. LOCATION (City, town, or county) (State): Westport Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Clinton E. Eliason ADDRESS: 1129 N. Carlisle St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-651

BIRTH NO. 67 0026

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0026

1. NAME OF DECEASED (Type or Print) AMY PAVOR ERNEST
ERNEST, AMY PAVOR

2. DATE AND HOUR OF DEATH 1-2-67 | 6:30P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Church Home & Hospital
100 N. Broadway
Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 604 S. Rose St.

1-03

5. SEX F
6. RACE W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH 2-16-93
9. AGE (In years last birthday) 73
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) VA.
12. CITIZEN OF WHAT COUNTRY? AMER.

13. FATHER'S NAME Perry Harris
14. MOTHER'S MAIDEN NAME ANNA Davis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-09-4245
17. INFORMANT HENRY ERNEST (Hus) ADDRESS 604 S. Rose St.

MEDICAL CERTIFICATION

18. 260 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebrovascular Accident — days
DUE TO Arteriosclerotic Heart Disease — years
Congestive Heart Failure
(B) Pneumonia — days
DUE TO
(C) Diabetes Mellitus — years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-26 19 66 to 1-2 19 67, that (I) (we) last saw the deceased alive on 1-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE N. Penaflor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED 1-2-67
23C. PHYSICIAN'S NAME (Type) NORMA PENAFLOR M.D.
23D. ADDRESS Church Home & Hospital 100 N. Broadway, Balto.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 1-6-1967
24C. NAME of CEMETERY or CREMATORY Mt. Carmel
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 4 1967
25B. NAME OF REGISTRAR
25C. FUNERAL DIRECTOR Dilly & Zeiler Inc. ADDRESS 1901-07 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0027
M.E. CASE NO.

Registered No. 67 0027

1. NAME OF DECEASED (Type or Print): PRITCHETT, GEORGE CLARENCE

2. DATE AND HOUR OF DEATH: January 1, 1967 | 11:10p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 810 N. Milton Avenue, Baltimore, Maryland 21213

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 7-07
D. STREET ADDRESS (If rural, give location): 810 N. Milton Avenue #5

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	married	2.8.1907	59 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Universal Machine Corp.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Warnie Pritchett

14. MOTHER'S MAIDEN NAME: Mabel R. Graves

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-07-5593

17. INFORMANT: Helen Pritchett, wife, above
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CANCER - COLON — 1-2 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
DEC 1966	DIAGNOSTIC	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9-25-65 19 to JAN 1967, that (I) (~~we~~) last saw the deceased alive on 12/31/66 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Benj. R. Moses, M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-3-67

23C. PHYSICIAN'S NAME (Type): Dr. Benj. Moses M.D.

23D. ADDRESS: 448 N. Luzerne Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/5/67	Oak Lawn Cemetery	Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 4 1967	[illegible]	Sahimunek Funeral Home, Inc.	2001-03-05 E. Madison Street #5

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-2001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. Havre de Grace, Md. 67 0028 — M.E. CASE NO. — Registered No. 67 0028

1. NAME OF DECEASED (Type or Print): Sherry Pugh — Sherry Lynn Pugh

2. DATE AND HOUR OF DEATH: Jan. 3, 1967 7:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~~Rosewood State Hosp.~~ 38 University Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Harford — Rosewood State Hosp
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Bel Air — 62-32
D. STREET ADDRESS (If rural, give location): 15 Dallam Ave.

5. SEX: F — 6. RACE: W — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): N. M. — 8. DATE OF BIRTH: 5/26/65 — 9. AGE (In years, last birthday): 19 months — If Under 1 Yr. Months, Days — If Under 24 Hrs. Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child — 10B. KIND OF BUSINESS OR INDUSTRY: None — 11. BIRTHPLACE (State or foreign country): Havre de Grace, Md. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Pugh — 14. MOTHER'S MAIDEN NAME: Linda Gross

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service): --- — 16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Thomas W. Pugh — ADDRESS: 15 Dallam Ave. Bel Air, Md. 21014

MEDICAL CERTIFICATION

1B. 493X I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) GI bleeding
DUE TO pneumonia
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. microcephalic

19A. DATE OF OPERATION: 2 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): Yes — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/30 1966 to 1/3 1966, that (I) (last saw the deceased alive on Jan. 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.

23A. SIGNATURE: Martha Leffler M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ — 23B. DATE SIGNED: Jan. 3, 1966

23C. PHYSICIAN'S NAME (Type): MARTHA LEFFLER M.D. — 23D. ADDRESS: University Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 1/5/1967 — 24C. NAME of CEMETERY or CREMATORY: Bel Air Memorial Gardens — 24D. LOCATION (City, town, or county) (State): Bel Air, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967 — 25B. NAME OF REGISTRAR: Robert E. Fahey — 25C. FUNERAL DIRECTOR: Charles E. Kurtz — ADDRESS: Jarrettsville, Md. 21084

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-40D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0029 Registered No. 67 0029

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ball Mable C.

2. DATE AND HOUR OF DEATH: Jan 2nd 1967 11 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: St. Mary's
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rural, St. Mary's county
D. STREET ADDRESS (If rural, give location): St. Inigoes. 68-00

5. SEX: F
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2/8 03
9. AGE (In years last birthday): 63
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Owner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James F. Ball
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningioma

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/28/66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Meningioma
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/25 1966 to 1/2 67 1966, that (I) (we) last saw the deceased alive on 1/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thor. Por Thorsteinsson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: Jan 2nd 66
23C. PHYSICIAN'S NAME (Type): V.T. Thorsteinsson M.D.
23D. ADDRESS: Univ. Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1.7.67
24C. NAME of CEMETERY or CREMATORY: Mt Zion Cemetery
24D. LOCATION (City, town, or county) (State): Saint Inigoes Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: [illegible] McTernan
ADDRESS: 2303 W North Ave Balt 16 Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-456

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0030 Registered No. 67 0030

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MALONE, ROBERT NMI

2. DATE AND HOUR OF DEATH: January 1, 1967 9:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: X
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 4-62
D. STREET ADDRESS (If rural, give location): 221 N. Fremont Ave.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12/24/95
9. AGE (In years last birthday): 71
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Robert Malone
14. MOTHER'S MAIDEN NAME: Betty

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 6/22/18-7/9/19
16. SOCIAL SECURITY NO.: PN605-12-24-95
17. INFORMANT: Veterans Hospital Records ADDRESS: Balto., Md. 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF THE PANCREAS — INTERVAL BETWEEN ONSET AND DEATH: 5 Months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 8, 1966 to January 1, 1967, that (I) (we) last saw the deceased alive on January 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/1/67
23C. PHYSICIAN'S NAME (Type): David N. Marine M.D.
23D. ADDRESS: Veterans Hospital, Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Arthur L. McCullough ADDRESS: 2302 W. Fairmount Balt. Md.

VS 150-REV. 1/1/65

F-632

BIRTH NO. 67 0031

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0031

1. NAME OF DECEASED (Type or Print): Henry W. Fritz

2. DATE AND HOUR OF DEATH: 1-3-1967 | 4:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21230
D. STREET ADDRESS (If rural, give location): 15 Poultney St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower
8. DATE OF BIRTH: 8-21-1885
9. AGE (In years): 81 (last birthday)
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Grocery
10B. KIND OF BUSINESS OR INDUSTRY: Own Grocery None
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam Geo Fritz
14. MOTHER'S MAIDEN NAME: Katherine Seigle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-44-6246
17. INFORMANT: Miss Caroline E. Fritz (Sister)
ADDRESS – same

MEDICAL CERTIFICATION

18. 443X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia — 48 hrs
DUE TO
(B) Hypertension — ? years
DUE TO
(C) Arteriosclerotic Cardiovascular Dis. — many years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — Hematuria – cause unknown probable chronic renal disease (by I.V.P.)

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12-28 1966 to 1-3 1967, that ~~(I)~~ (we) last saw the deceased alive on 1-3 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: David J. Steinhauer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): DAVID J. STEINHAUER M.D.
23D. ADDRESS: 1013 LIGHT ST 21230

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: FRI – JAN 6-1967
24C. NAME of CEMETERY or CREMATORY: CEDAR HILL CEM
24D. LOCATION (City, town, or county) (State): BROOKLYN B.A.CO. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: CURTIS E. EVANS
ADDRESS: 1400 S. CHARLES ST 21230

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0032 Registered No. 67 0032

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Moses Lynch

2. DATE AND HOUR OF DEATH: 1/1/67 6 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 2007
D. STREET ADDRESS (If rural, give location): 3409 W. Franklin St

5. SEX: M 6. RACE: C 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M 8. DATE OF BIRTH: 1/6/1904 9. AGE (In years last birthday): 62 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disabled 10B. KIND OF BUSINESS OR INDUSTRY: Painter 11. BIRTHPLACE (State or foreign country): Halifax Co., N.C. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morland Lynch 14. MOTHER'S MAIDEN NAME: Anna Long

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 237-18-2524 17. INFORMANT: Annie May Lynch ADDRESS: wife

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Staphylococcal septicemia — ? - week

DUE TO

(B) Basilar Artery - insuff. — 4 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/20 19 66 to 1/1 19 67, that (I) (we) last saw the deceased alive on 1/1/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P.P. Toskes M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): P.P. Toskes M.D. 23D. ADDRESS: Univ. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1-2-67 24C. NAME of CEMETERY or CREMATORY: Mt. Auburn 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967 25B. NAME OF REGISTRAR: Robert E. Talley M.D. 25C. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

V-516

67 0033

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0033

BIRTH NO. 66-16244

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rachel Vanbraus

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 10:26 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01

D. STREET ADDRESS (If rural, give location): 1240 E. Eager St.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: Oct. 2, 1966

9. AGE (In years last birthday): ~~[illegible]~~

If Under 1 Yr. or Under 24 Hrs.: Months 5 | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Willie Vanbraus

14. MOTHER'S MAIDEN NAME: Barbara Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Willie Vanbraus

ADDRESS: SAME

MEDICAL CERTIFICATION

18. 525 X

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis (SDII)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bilateral otitis media

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-5-67

23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.

23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

24B. NAME OF REGISTRAR: [illegible]

24C. FUNERAL DIRECTOR: Conroy & Walsom

ADDRESS: 1000 Brantley Ave.

VS 151-REV. 1/1/65

C-152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0034 Registered No. 67 0034

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Covington, James

2. DATE AND HOUR OF DEATH: 1-2-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1640 E Preston St.

3-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	C		10/31/18	48 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Scrap Corp. of Amer.	Rockingham, N.C.	U.S.A

13. FATHER'S NAME: John B. Covington

14. MOTHER'S MAIDEN NAME: Alice Bride

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 348-38-3348

17. INFORMANT: Brother ADDRESS:

MEDICAL CERTIFICATION

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Subarachnoid Hemorrhage — 3½ hrs.
DUE TO
(B) Essential Hypertension
DUE TO
(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

NOT A MEDICAL EXAMINER'S CASE — CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/2 1967 to 1/2 1967, that (I) (we) last saw the deceased alive on 1/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ | 23B. DATE SIGNED: 1/2/66

23C. PHYSICIAN'S NAME (Type): NENITA SUAREZ M.D. | 23D. ADDRESS: Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Bench	1-7-67	Rockingham Cemt	Rockingham N. Carolina

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967 | 25B. NAME OF REGISTRAR: [signature] | 25C. FUNERAL DIRECTOR: ~~Chas. E. Wilson 1000 Broadway Ave.~~ ADDRESS: Nelson's Funeral Home, Rockingham, N.C.

VS 150-REV. 1/1/65

to be signed by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
A-516

67 0035

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0035

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HAROLD V. AMBROSE

2. DATE AND HOUR PRONOUNCED DEAD: January 1, 1967 | 9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): South Baltimore General Hospital

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04

D. STREET ADDRESS (If rural, give location): 1615 Light Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Dec. 9, 1910

9. AGE (In years last birthday): 56

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10B. KIND OF BUSINESS OR INDUSTRY: Glass Co.

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Harry Ambrose

14. MOTHER'S MAIDEN NAME: Olive Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes # 2

16. SOCIAL SECURITY NO.: 217 10 4132

17. INFORMANT: Mrs. Margaret G. Ambrose

ADDRESS: 1615 Light St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/2/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1 5 1967

23C. NAME of CEMETERY or CREMATORY: U. S. National

23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

24B. NAME OF REGISTRAR: Geo. E. Fulton

24C. FUNERAL DIRECTOR: Mc Cully

ADDRESS: 130 E. Fort Ave

0 0 0 3 4

VS 151-REV. 1/1/65

D-514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0036 Registered No. 67 0036

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dimpfel, Floy

2. DATE AND HOUR OF DEATH: 1-2-67 | 7.55P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bolton Hill Nursing Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: 27-34

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): ~~1400 John St.~~ 4106 GRANITE AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	10-2-1890	76		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Norfolk Va.	U.S.A.

13. FATHER'S NAME: Joseph C. Baum

14. MOTHER'S MAIDEN NAME: Carrie Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Virginia Silver ADDRESS: 4009 Glenarm Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL VAS. ACC. & APHASIA and Hemiparesis — 6/66

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Stasis ulcer ~~left~~ leg and hip 7/66

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 7 1966 to 1/2 1967 that (I) (we) last saw the deceased alive on 1/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allan Macht M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/3/67

23C. PHYSICIAN'S NAME (Type): ALLAN H. MACHT M.D.

23D. ADDRESS: 2 EAST READ ST 21202

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 1-3-67

24C. NAME of CEMETERY or CREMATORY: Greenmount Crematory

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: R. E. Fahey M.D.

25C. FUNERAL DIRECTOR: John C. Miller Inc. ADDRESS: 6415 Belair Rd. - 21206

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-410

BIRTH NO. 67 0037

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0037

1. NAME OF DECEASED (Type or Print): IDA SILVA

2. DATE AND HOUR OF DEATH: Jan 2/67 | 12:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): George Washington Convey Nursing Home 607 Penna Ave.

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 734 Pierce street

5. SEX: F.
6. RACE: Col.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed.
8. DATE OF BIRTH: 2/10/00
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Middleton
14. MOTHER'S MAIDEN NAME: ? Diamon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Chart # 163 ADDRESS: 607 Penna Ave.

MEDICAL CERTIFICATION

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro vascular accident
DUE TO
(B) Arteriosclerotic Cardio vascular disease — 6 yrs.
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/13 1960 to 1/1 1967, that (I) (we) last saw the deceased alive on 1/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. N. Mac Murchy M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): J. N. MAC MURCHY M.D.
23D. ADDRESS: 607 Penna Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-411

BIRTH NO. 67 0038

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0038

1. NAME OF DECEASED (Type or Print): Mrs. MARY B. COULBOURN

2. DATE AND HOUR OF DEATH: 1-3-67 | 8 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MELCHOR NURSING HOME 2723 Charles Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 9-03

D. STREET ADDRESS (If rural, give location): 3630 OLD YORK Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: Aug 19, 1889

9. AGE (In years last birthday): 77 yrs

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Bennington

14. MOTHER'S MAIDEN NAME: Emma

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MR. HOWARD T. Coulbourn

ADDRESS: Same as #3

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. #201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Myocardial Infarction

DUE TO

(B) ASCVD

DUE TO

(C) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-29-1963 to 1-3-1967, that (I) (we) last saw the deceased alive on 1-3-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar Valle Cavero M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-3-67

23C. PHYSICIAN'S NAME (Type): CESAR VALLE CAVERO M.D.

23D. ADDRESS: 8629 Liberty Rd.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/67

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: C. E. Fahey M.D.

25C. FUNERAL DIRECTOR: Wm Cook Broth, Inc.

ADDRESS: 1217 St Paul St Baltimore MD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0039 Registered No. 67 0039

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN F. PERRY

2. DATE AND HOUR OF DEATH: 1-2-67 5:50 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): COCKEYSVILLE
D. STREET ADDRESS (If rural, give location): 10744 YORK ROAD

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3-7-06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UPHOLSTERER
10B. KIND OF BUSINESS OR INDUSTRY: UPHOLSTERING
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM PERRY
14. MOTHER'S MAIDEN NAME: DORA GREEN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-09-4603
17. INFORMANT: MRS. VIRGIE V. PERRY ADDRESS: SAME AS 4-D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Ca of Lung — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 6/3/66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of Lung
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 1966 to Jan 2 1967, that (I) (we) last saw the deceased alive on Jan 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ([redacted]) view the body after death.

23A. SIGNATURE: Robert D. Pipkin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/2/67
23C. PHYSICIAN'S NAME (Type): ROBERT D. PIPKIN M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-5-67
24C. NAME of CEMETERY or CREMATORY: JESSOPS CEMETERY
24D. LOCATION (City, town, or county) (State): COCKEYSVILLE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: W.M. COOK BROOKS TOWSON
ADDRESS: 1050 YORK RD. TOWSON, MD. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

A-520

67 0040

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0040

BIRTH NO.

M.E. CASE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Charles Amick Jr.

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 4:34 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED 1-12-67

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-02

D. STREET ADDRESS (If rural, give location): 1801 N. Gay St.

33

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white		11/14/16	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	--------	Baltimore, Md.	USA

13. FATHER'S NAME: Charles Amick

14. MOTHER'S MAIDEN NAME: Blanch Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW11 entered 10/23/42 discharged 7/3/43	216-09-2313	Mrs Louise Rosenberger	1801 N Gay St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ ~~Inspection~~ ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/6/67	Baltimore National Cem.	Baltimore County, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 4 1967		Wm. Cook-Brooks F.H.	Balto. Md. 21202 1217 St. Paul St.

VS 151-REV. 1/1/65

Letter from M.E.'s Office 1-12-67 M.H.

1

D-520

67 0041

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0041

Registered No.

1. NAME OF DECEASED (Type or Print): John Dennis

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 12:43 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2009 Brunt St.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03

D. STREET ADDRESS (If rural, give location): 2009 Brunt St.

5. SEX: male

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 12-8-89

9. AGE (In years last birthday): 78

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alex Dennis

14. MOTHER'S MAIDEN NAME: Elizabeth Norris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lilly Mae Dennis ADDRESS: 2009 Brunt Street

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-6-67

23C. NAME of CEMETERY or CREMATORY: Baltimore Nat'l. Cem.

23D. LOCATION (City, town, or county) (State): Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

H-6-32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0042 Registered No. 67 0042

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARDISON Addie

2. DATE AND HOUR OF DEATH: 1/2/67 5:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-01

D. STREET ADDRESS (If rural, give location): 1724 N. CALHOUN ST.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
FEMALE	NEGRO	MARRIED	11-19-10	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLIE GRAVES

14. MOTHER'S MAIDEN NAME: ADA GRAVES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles Hardison ADDRESS: 1725 Calhoun Street

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Embolus - suspected Immed

DUE TO

(B) Carcinomatosis - primary undetermined

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/12 19 66 to 1/2 19 67, that (I) (we) last saw the deceased alive on 1/2/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. H. Brown III M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/2/67

23C. PHYSICIAN'S NAME (Type): C. H. BROWN 111 M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-7-67	Arbutus Mem. Pk.	Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0043 Registered No. RUFF 67 0048 LE C.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUFFIN, ANNABELLE C

2. DATE AND HOUR OF DEATH: 7 30 AM 1/2/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: 15 47

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2305 KOKO LANE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	N	MARRIED	12-21-1925	41		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher	Public School	Baltimore Maryland	U.S.A.

13. FATHER'S NAME: John Moore

14. MOTHER'S MAIDEN NAME: MABLE RHOE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	No	216-20-4840	Earl L. Ruffin	2305 KoKo Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Renal failure	3 months
DUE TO (B)	glomerulonephritis	- years
DUE TO (C)	Hypertension ?	yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	YES	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ — Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from 12/29 1966 to 1/2 1966, that (I) (~~we~~) last saw the deceased alive on 1/2 1966 and that in (~~my~~) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: S. Nishkin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/2/66

23C. PHYSICIAN'S NAME (Type): S. NISHKIN M.D.

23D. ADDRESS: JHH

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1/6/67	Baltimore National Cem.	Baltimore	Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 4 1967	[illegible]	Herbert E. Nutter	3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H 163 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0044 Registered No. 67 0044

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): KENNETH PHILLIP HUBBARD

2. DATE AND HOUR OF DEATH: JAN 4 1967 | 230 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2042 E BALTIMORE ST

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 6-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2042 E BALTIMORE ST

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: MAR 25 1925
9. AGE (In years last birthday): 41
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10B. KIND OF BUSINESS OR INDUSTRY: BETH STEEL CO
11. BIRTHPLACE (State or foreign country): STONE KENTUCKY
12. CITIZEN OF WHAT COUNTRY?: U.S.A
13. FATHER'S NAME: S. L. HUBBARD
14. MOTHER'S MAIDEN NAME: MAUDE UNK
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): WORLD WAR II
16. SOCIAL SECURITY NO.: 402-28-7438
17. INFORMANT: AGNES A HUBBARD ADDRESS: 2042 E BALTO ST

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis — acute
DUE TO
(B) Coronary Insufficiency — 2 months
DUE TO
(C) Angina Pectoris attacks

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept. 13 1966 to Jan. 2 1967, that (I) (we) last saw the deceased alive on Jan. 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Death occurred 1/4/67 at 2:30 AM

23A. SIGNATURE: I. J. Feinglos M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/4/67
23C. PHYSICIAN'S NAME (Type): I. J. FEINGLOS M.D.
23D. ADDRESS: 1007 E. Pratt St

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN 6 67
24C. NAME of CEMETERY or CREMATORY: BALTIMORE NATIONAL CEM
24D. LOCATION (City, town, or county) (State): FREDERICK RD MD

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: DIPPEL BROS INC ADDRESS: 1806 LOMBARD ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-605

BIRTH NO. 67 0045

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0045

1. NAME OF DECEASED (Type or Print): Gerhard Rudolf Tari

2. DATE AND HOUR OF DEATH: Jan. 2, 1967 | 5 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #13 26-03

D. STREET ADDRESS (If rural, give location): 2925 Edison Highway

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: June 17, 1903.

9. AGE (In years last birthday): 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY: Wahman Co.

11. BIRTHPLACE (State or foreign country): Estonia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Tari

14. MOTHER'S MAIDEN NAME: Leena Michaelson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-30-7240

17. INFORMANT: Mrs. Hilda Tari

ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 19 1964 to Jan 2, 1967, that (I) (we) last saw the deceased alive on Dec 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis Krause M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-3-67

23C. PHYSICIAN'S NAME (Type): Louis Krause M.D.

23D. ADDRESS: 11 E Chase St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/67.

24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc Baltimore, Md.

ADDRESS

JAN 4 1967

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6 112

BIRTH NO. 67 0046

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0046

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MRS. DOROTHY BARBAGALLO

2. DATE AND HOUR OF DEATH: JANUARY 3, 1967 | 10:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: CHURCH HOME + HOSPITAL
(If not in hospital or institution, give street address or location): BALTIMORE, MARYLAND, 21231

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE #24
D. STREET ADDRESS (If rural, give location): 7615 CARSON AVE

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-18-20
9. AGE (In years last birthday): 46
If Under 1 Yr. Months: 8 Days: 15 | If Under 24 Hrs. Hours: | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN DORZEY
14. MOTHER'S MAIDEN NAME: MARY (Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Sebastian Barbagallo, HUSBAND
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) GENERALIZED CARCINOMATOSIS — APPROXIMATELY
DUE TO
(B) CARCINOMA OF THE OVARY — 4 MONTHS
DUE TO
(C) PLEURAL EFFUSION

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: N.A.
20A. AUTOPSY? (Yes or No): NONE
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-21-6 1966 to 1-3 1967, that (I) (we) last saw the deceased alive on 1-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jose G. Ortiz M.D.
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-3-67
23C. PHYSICIAN'S NAME (Type)
23D. ADDRESS
M.D.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/67.
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR:
25C. FUNERAL DIRECTOR: Leonard J. Huck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

[redacted]

M-250

BIRTH NO. 67 0047

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0047

1. NAME OF DECEASED (Type or Print): William O. McKenna

2. DATE AND HOUR OF DEATH: Jan. 3, 1967 | 1:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Nottingham Village, Balto. #6

D. STREET ADDRESS (If rural, give location): 9225 Ravenwood Road

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: Aug. 12, 1906.

9. AGE (In years last birthday): 60

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Internal Revenue Service

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William E. McKenna

14. MOTHER'S MAIDEN NAME: Rose ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W 2

16. SOCIAL SECURITY NO.: 213-03-5324

17. INFORMANT: Frances McKenna ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) hypertensive CVD — INTERVAL BETWEEN ONSET AND DEATH: 8-10yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb 1956 to Jan 3 1967, that (I) (we) last saw the deceased alive on Jan 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: B. Meech MD M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): BURTON V. LOCK M.D.

23D. ADDRESS: 2936 E Balto St 21224

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 1/7/67.

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0048 Registered No. 67 0048

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PATRICK J. KINSELLA

2. DATE AND HOUR OF DEATH: January 3, 1967 | 11:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 309 E. 25th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-03

D. STREET ADDRESS (If rural, give location): 309 E. 25th St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	married	Jan. 14, 1893	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
milkman		Ireland	USA

13. FATHER'S NAME: James Kinsella

14. MOTHER'S MAIDEN NAME: Mary Flannigan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-10-3898

17. INFORMANT: Miss Mary Kinsella ADDRESS: 309 E. 25th St., Balto.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Severe Asthma + Chronic Emphysema + Obstructive — Years

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES: WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from May 12, 1965 to Present 19..., that (~~I~~) (we) last saw the deceased alive on January 3 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Herman Brecher M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): Dr. Herman Brecher M.D.

23D. ADDRESS: 443 E. 25th St., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1/7/67.	New Cathedral	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Lebhard J. Ruck, Inc.--Baltimore, Md.-14 ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0049 Registered No. 67 0049

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William S. Clark

2. DATE AND HOUR OF DEATH: 1/1/67 11:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: AA

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Glen Burnie 62-00

D. STREET ADDRESS (If rural, give location): 3 Amelia Ave. N. E.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	Dec. 31, 1897	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Crane Operator		Kentucky	USA

13. FATHER'S NAME: Henry Clark

14. MOTHER'S MAIDEN NAME: Mary Lambert

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 278-05-6870

17. INFORMANT: Mrs. Doris Clark, same as 4 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

463X

(A) Multiple Pulmonary Infarcts — 3 days.

DUE TO

(B) Propagating clot - (L) femoral, iliac vein, (R) ventricle — 3 days - 1 week.

DUE TO

(C) Bedridden — 13 days

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Pneumonia, severe Pulmonary Emphysema

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None	—	Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 1/1 19 67 to 1/1 19 67, that (I) (we) last saw the deceased alive on 1/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Philip B Dvoski M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/2/67

23C. PHYSICIAN'S NAME (Type): Philip B. Dvoski, M. D. M.D.

23D. ADDRESS: Mercy Hospital, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/5/67	Cedar Hill Cemetery	Baltimore, Md. 21225

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Bushby Funeral Home ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-3

BIRTH NO. 67 0050

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0050

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Kenneth Watts

2. DATE AND HOUR OF DEATH: January 3, 1967 | 12:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: AA
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 32-00
D. STREET ADDRESS (If rural, give location): 606 Surfside St 21225

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8/1/15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steelworker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howell Watts
14. MOTHER'S MAIDEN NAME: Lillian Tayman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W W 11
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family
ADDRESS: Same

MEDICAL CERTIFICATION

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarction — Hours
DUE TO

(B)
DUE TO

(C) Arteriosclerotic Heart Disease — Years

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 2 1967 to January 3 1967, that (I) (we) last saw the deceased alive on Jan. 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John Gary Green M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Jan 3, 1967
23C. PHYSICIAN'S NAME (Type): John Gary Green M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/67
24C. NAME of CEMETERY or CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glen Burnie AA Co Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: McCully F H
ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

F-26

BIRTH NO. 67 0051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0051

M.E. CASE NO.

FISHER, LINDA LEE 13

1. NAME OF DECEASED (Type or Print): LINDA LEE FISHER

2. DATE AND HOUR OF DEATH: 1-1-67 CHERRY 1235 AM. 311 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: 07-22-46 Balto

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~XXXXXXXXXXXX~~ English Consul

D. STREET ADDRESS (If rural, give location): 3312 HOLLINS FERRY RD.

5. SEX: F

6. RACE: CAUC.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 8-13-53

9. AGE (In years last birthday): 13

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NOLLEY E. FISHER

14. MOTHER'S MAIDEN NAME: ALBERTA ~~XXXXXXXX~~ A. Fish

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Nolley E. Fisher ADDRESS: ~~XXXXXXXX~~ 3312 Hollins Ferry Rd. 21227

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Eisenmenger's Complex — 12 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 12/31 1966 to 1-1 1967, that ~~I~~ (we) last saw the deceased alive on 1-1-~~66~~ 67 19 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Mary Beth Keeler M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-1-67

23C. PHYSICIAN'S NAME (Type): MARY BETH KEELER M.D.

23D. ADDRESS: UNIV. HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-4-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: [illegible] Balto. Md.

25C. FUNERAL DIRECTOR: Howard H. Hubbard ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-326

BIRTH NO. 67 0052

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0052

1. NAME OF DECEASED (Type or Print): DITCH, CLYDE W.

2. DATE AND HOUR OF DEATH: 1-2-67 2:50P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: ANNE ARUNDEL

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE

52-00

D. STREET ADDRESS (If rural, give location): 1111 ARMSTEAD STREET

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 4-28-06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pen Guard

10B. KIND OF BUSINESS OR INDUSTRY: Md Pen.

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM DITCH

14. MOTHER'S MAIDEN NAME: IDA KING

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST. AGNES RECORDS -CATON & WILKENS AVES ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) METASTATIC CARCINOMA LUNG. TO POSTERIOR WALL OF TRACHEA ETC. — 8 YEARS

DUE TO

(B) CHRONIC BRONCHITIS & EMPHYSEMA ASTHMATIC — 10 YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

29

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVHD & PHx MYOCARDIAL INFARCTION 3YRS

19A. DATE OF OPERATION: 1/1/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: RESPIRATORY DISTRESS

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from DECEMBER 30 1966 to JANUARY 2 1967, that (I) (we) last saw the deceased alive on JANUARY 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Leymond W. Lott M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): LEYMOND W. LOTT M.D.

23D. ADDRESS: 529 CAMP MEADE RD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/67

24C. NAME of CEMETERY or CREMATORY: Glen Haven

24D. LOCATION (City, town, or county) (State): Glen Burnie AA Co Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: McCully F H 237 Patapsco Ave ADDRESS 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0053 Registered No. 67 0053

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FOURLAS, EVANGELINE

2. DATE AND HOUR OF DEATH: 1-1-67 | 5:00AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: PENNSYLVANIA B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): CARLISLE

D. STREET ADDRESS (If rural, give location): 136 C STREET

V-35

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	WIDOW	1-20-94	72		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: THEODORE PATEREKAS

14. MOTHER'S MAIDEN NAME: VASILIKI KARAGEORGE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Nicholas J. Fourlas ADDRESS: 136 "C" Street -Carlisle, Pa.

MEDICAL CERTIFICATION

18. 154 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) MI, CVA, wound infection — 10/28/66 → 1/1/67

DUE TO

(B) Surgical intervention for

DUE TO

(C) invasive papillary adenoca of rectum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

19A. DATE OF OPERATION: 10/28/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Adenoca of rectum

20A. AUTOPSY? (Yes or No): No.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/30 1966 to 1/1 1967, that (I) (we) last saw the deceased alive on 12/31 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. L. Hurwitz M.D. Attending Phys. ☐ Med. Director ☐ House Staff Phys. ✓

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): Richard L Hurwitz M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/4/67

24C. NAME of CEMETERY or CREMATORY: Westminster Cemetery

24D. LOCATION (City, town, or county) (State): N. Middleton Twp., Cumb., Pa.

25A. DATE REC'D BY HEALTH DEPT.: JAN 4 1967

25B. NAME OF REGISTRAR: Louis E. Tabaka M.D.

25C. FUNERAL DIRECTOR: Jacob Hartenstein ADDRESS: New Freedom, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0054 Registered No. 67 0054

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BOGARTY, Mrs CONSTANCE

2. DATE AND HOUR OF DEATH: 1/3/67 12-50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church home & hospital 100 N. Broadway. 35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Balto. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 5306 Gwynndale Ave

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7/4/16

9. AGE (In years last birthday): 50 yrs

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): ~~Maryland~~ PA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Carlson.

14. MOTHER'S MAIDEN NAME: Ebba Hansen.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-07-3389

17. INFORMANT: Dr K. M. Anandaiah. ADDRESS: Church home & hosp

MEDICAL CERTIFICATION

1B. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Cervix

DUE TO

(B) Metastatic to Brain?

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3 1967 to 1/3 1967, that (I) (we) last saw the deceased alive on 1/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: K. M. Anandaiah. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/3/67.

23C. PHYSICIAN'S NAME (Type): K. M. ANANDAIAH M.D.

23D. ADDRESS: Church home & hospital Baltimore.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: WOODLAWN

24D. LOCATION (City, town, or county) (State): WOODLAWN MD

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: J.T. STANSBURY ADDRESS: BALTO. MD

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-152

BIRTH NO. 67 0055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 67 0055

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): KNUPPINGER, JOHN R.

2. DATE AND HOUR OF DEATH: 1-2-67 | 9:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital 100 N. Broadway Baltimore

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balt. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 925 Kenilworth Dr.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 9-3-12

9. AGE (In years last birthday): 54

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Disability

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. J.

12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: JOHN D. KNUPPINGER

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Etta May Rogers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W II

16. SOCIAL SECURITY NO.: 111-05-5309

17. INFORMANT: FRANCIS KNUPPINGER (wife) ADDRESS: 925 Kenilworth

MEDICAL CERTIFICATION

1B. 5-22-1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Pulmonary failure

DUE TO Chronic Emphysema

(B) Pneumonia

DUE TO Arterio Sclerotic Heart Disease

(C)

INTERVAL BETWEEN ONSET AND DEATH: 1 year / days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-21 19 66 to 1-2 19 67, that (I) (we) last saw the deceased alive on 1-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: N. Penafler M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-2-67

23C. PHYSICIAN'S NAME (Type): NORMA PENAFLOR M.D.

23D. ADDRESS: Church Home & Hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9-5-67

24C. NAME of CEMETERY or CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Baltimore County, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc. ADDRESS: 6500 York Rd. Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-420

BIRTH NO. 67 0056

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0056

1. NAME OF DECEASED (Type or Print): Carrie Klug

2. DATE AND HOUR OF DEATH: January 2, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3939 Penhurst Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-02

D. STREET ADDRESS (If rural, give location): 1511 Hopewell Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	White	Widowed	April 25, 1883	83				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? Hohman

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Carolyn Sullens ADDRESS: 1511 Hopewell Ave. 21221

MEDICAL CERTIFICATION

18. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Senile Dementia — 10 yrs

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension CVD

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 19 66 to 1-2 19 67, that (I) (we) last saw the deceased alive on Dec-31-1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wm Thos G Abbott M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-3-66

23C. PHYSICIAN'S NAME (Type): Thomas G Abbott M.D.

23D. ADDRESS: 4509 Liberty Heights Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State): ~~Baltimore Md.~~ Colgate, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Ulrich Funeral Home ADDRESS: 4210 Belair Road.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0057 Registered No. 67 0057

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN ~~MAC~~ WILLIAM MACKERT

2. DATE AND HOUR OF DEATH: 1/1/67 2:05 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-34

D. STREET ADDRESS (If rural, give location): 5617 BENTON HEIGHTS AVE.

5. SEX: M

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): (circled)

8. DATE OF BIRTH: 3/6/1898

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10B. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. MACKERT

14. MOTHER'S MAIDEN NAME: CATHERINE GLUCK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MYRTLE E. MACKERT ADDRESS: 5617 BENTON HEIGHTS AVE.

MEDICAL CERTIFICATION

18. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) CEREBRAL HEMORRHAGE

DUE TO & G-I BLEEDING

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/24 1966 to 1/1 1967, that (I) (we) last saw the deceased alive on 1/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Tomas A. Alvero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): TOMAS A. ALVERO M.D.

23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-4-67

24C. NAME of CEMETERY or CREMATORY: PARKWOOD CEMETERY

24D. LOCATION (City, town, or county) (State): BALTO. CO., MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: ULRICH FUNERAL HOME ADDRESS: BALTO., MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-400 1

BIRTH NO. 67 0058

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0058

1. NAME OF DECEASED (Type or Print): Sophia Milli

2. DATE AND HOUR OF DEATH: Jan. 1, 1967 | 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 57 Vista Mobile Dr.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 11/1/84

9. AGE (In years last birthday): 82

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? — RODOLF

14. MOTHER'S MAIDEN NAME: ?CATHERINE PORT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Catherine Smith (daughter) ADDRESS: Same

MEDICAL CERTIFICATION

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure — 2 months

DUE TO

(B) Atherosclerotic Cardiovascular Dis. — years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 25 1966 to Jan. 1 1967, that (I) (we) last saw the deceased alive on Jan. 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): W. MICHAEL GOULD M.D.

23D. ADDRESS: Md. Gen Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/5/67

24C. NAME of CEMETERY or CREMATORY: BEL AIR MEMORIAL GARDENS

24D. LOCATION (City, town, or county) (State): HARFORD COUNTY, MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Ulrich Funeral Home, Dundalk, MD.

ADDRESS:

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

B-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0059 Registered No. 67 0059

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BAYNES, HENRY THOMAS

2. DATE AND HOUR OF DEATH: JANUARY 3, 1967 6:00P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

ST. AGNES HOSPITAL
CATON AND WILKENS AVENUES
BALTIMORE, MD. 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21207 Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 2131 GWYNN OAK AVENUE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 4-11-89

9. AGE (In years last birthday): 77

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED-FLORIST

10B. KIND OF BUSINESS OR INDUSTRY: FLORIST

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS BAYNES DEC'D

14. MOTHER'S MAIDEN NAME: ELIZABETH (BAMBERGER) DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOSPITAL SLIP-ST. AGNES HOSPITAL

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Emphysema

DUE TO

(B) Cor Pulmonale

DUE TO

(C) Atrial Fibrilation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rt Pneumonitis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from DECEMBER 11, 19 66 to JANUARY 3, 19 67, that (X) (we) last saw the deceased alive on ~~XXXXXX~~JAN. 3, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (~~XXXX~~) view the body after death.

23A. SIGNATURE: E.W. Weiss M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-03-67

23C. PHYSICIAN'S NAME (Type): E.W. WEISS M.D.

23D. ADDRESS: BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVE.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/66

24C. NAME of CEMETERY or CREMATORY: LORRAINE PARK Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR: Thomas J Kenny Inc

ADDRESS: Balto Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-5 36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0060 Registered No. 79760

M.E. CASE NO. 67 0060

1. NAME OF DECEASED (Type or Print): SNYDER, ARTHUR L.

2. DATE AND HOUR OF DEATH: Jan 3, 1967 1:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, MD 23 19-04
D. STREET ADDRESS (If rural, give location): 1634 Cole St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	5/8/96	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disabled

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): DURBIN, W. VA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CHARLES SNYDER

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Army, 1918

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. 241X 251X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cor-pulmonale
DUE TO
(B) Congestive heart failure due to Bronchiectasis
DUE TO
(C) Ca of Stomach

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca of Stomach

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 2, 11:00 P.M. 1967 to Jan 3, 1:55 P.M. 1967, that (I) (we) last saw the deceased alive on 1:55 P.M. Jan 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chang Kue Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Jan 3/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: Franklin Square Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: Thomas J. Kenny Inc

ADDRESS: Balto Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-600

67 0061

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0061

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sylvester Cherry JR.

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 1:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06

D. STREET ADDRESS (If rural, give location): 1610 N. Regester St.

5. SEX: male

6. RACE: colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 9-5-1958

9. AGE (In years last birthday): 8

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SYLVESTER CHERRY SR.

14. MOTHER'S MAIDEN NAME: AILENE Boyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: SYLVESTER CHERRY SR. ADDRESS: 1610 R EGESTER ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): E802 X

(A) Multiple injuries

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): railroad tracks

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Broadway overpass 8-07

21D. TIME OF INJURY (APPROX.): (Month) 1 (Day) 2 (Year) 67 (Hour) 12:34p M.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? struck by train while playing on tracks

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 1-7-67

23C. NAME of CEMETERY or CREMATORY: MT CAVARY

23D. LOCATION (City, town, or county) (State): A.A. County Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR:

24C. FUNERAL DIRECTOR: JOSEPH KNIGHT ADDRESS: 1639 N. BROADWAY

VS 151-REV. 1/1/65

N869.2

48-12-90 ED 1

BIRTH NO. -240 67 0062

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0062

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): John Mosely

2. DATE AND HOUR OF DEATH: 1-3-67 | 2.05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave., Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1514 W. Madison Ave.

14402

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5-? -92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Perry

14. MOTHER'S MAIDEN NAME: Theresa

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ?

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-8567

17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.

ADDRESS # 21224

MEDICAL CERTIFICATION

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Prostate

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-17 1966 to 1-3 1967, that (I) (we) last saw the deceased alive on 1-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard L. Bishop M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-3-67

23C. PHYSICIAN'S NAME (Type): Richard L. Bishop M.D.

23D. ADDRESS: Baltimore City Hospitals, 4940 Eastern Ave. Baltimore, Md. # 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/67

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetry

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT. JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS 1206 W North Ave

VS 150-REV. 1/1/65

L-0001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0063 Registered No. 67 0063

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DAVID PALMER LEE

2. DATE AND HOUR OF DEATH: 1/3/67 10:0 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: X

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 25-32

D. STREET ADDRESS (If rural, give location): 2914 Shelman Rd.

5. SEX: M

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 7/26/30

9. AGE (In years last birthday): 36

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES E. LEE

14. MOTHER'S MAIDEN NAME: MABLE PALMER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-28-1797

17. INFORMANT: MRS THOMAS ROBINSON ADDRESS: 3116 WOLCOTT AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 204.3

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE LYMPHOCYTIC LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: 14 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/25/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: TRACHEOTOMY

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/19 19 66 to 1/3 19 67, that ~~(I)~~ (we) last saw the deceased alive on 1/3 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Zalman S. Agus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/3/67

23C. PHYSICIAN'S NAME (Type): ZALMAN S. AGUS M.D.

23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/67

24C. NAME of CEMETERY or CREMATORY: MT AUBURN

24D. LOCATION (City, town, or county) (State): BALTIMORE MD

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Nicholas R. Hayes ADDRESS: 638 N Gilmor St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

W. 452

BIRTH NO. 67 0064

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0064

1. NAME OF DECEASED (Type or Print): Lorraine Wellington

2. DATE AND HOUR PRONOUNCED DEAD: 1/3/67 12:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Virginia

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newport News V-43

D. STREET ADDRESS (If rural, give location): 3407 ~~3404~~ Ronoke Ave.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 1917

9. AGE (In years last birthday): 49

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jacquline Scott

ADDRESS: 3306 N. Hilton St.

MEDICAL CERTIFICATION

18. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, ~~M.D.~~ M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/9/67

23C. NAME of CEMETERY or CREMATORY: Hampton National

23D. LOCATION (City, town, or county) (State): Hampton, Virginia

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR: Robert E. Fabian

24C. FUNERAL DIRECTOR: Charles A. Rice

ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

5-3201

BIRTH NO. 67 0065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0065

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Stephan Stach

2. DATE AND HOUR OF DEATH: January 3rd. 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Johns Hopkins Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 7612 Brightside Ave. 6
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Rosedale Md. Balto. Co.
D. STREET ADDRESS (If rural, give location): 7612 Brightside Ave. 6 53-00

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: April 17, 1887
9. AGE (In years last birthday): 79
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Czechoslovak
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Stephan Stach
14. MOTHER'S MAIDEN NAME: ----

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 213-48-3002
17. INFORMANT: Mrs. Frances J. Weinhold, 6712 Brightside Ave 6 ADDRESS

MEDICAL CERTIFICATION

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Coronary Occlusion
DUE TO
(B) Arteriosclerotic Coronary Artery Disease
DUE TO
(C) Diabetes mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from 19 65 to 19 67, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John G. Orth, M.D. M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/5/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 7/67
24C. NAME of CEMETERY or CREMATORY: Sacred Heart Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: Philip Hirwitz Sons
ADDRESS: 2024 Orleans St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260

BIRTH NO. 67 0066

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0066

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harry Baker

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 12:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 5438 Bellevista

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2234

D. STREET ADDRESS (If rural, give location): 5438 Bellevista

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 6-27-1898

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Baker

14. MOTHER'S MAIDEN NAME: Boone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-07-7741

17. INFORMANT: H.Edmund Baker

ADDRESS: 922 Wilton Drive # 27

MEDICAL CERTIFICATION

18. 422.1 I 002.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis and carcinoma of larynx

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-6-67

23C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR: Robert E. Fahey

24C. FUNERAL DIRECTOR: Ellsworth Armacost

ADDRESS: 4600 Liberty Hghts.

VS 151-REV. 1/1/65

W-2360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0067 Registered No. 67 0067

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WHITE, NANNIE

2. DATE AND HOUR OF DEATH: 1/3/67 7:15 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-66
D. STREET ADDRESS (If rural, give location): 2921 WALBROOK AVE.

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: NOV. 13, 1897
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BEVERLY JONES
14. MOTHER'S MAIDEN NAME: ILLINOIS JONES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-18-3831
17. INFORMANT: FLOYD WHITE ADDRESS: 2921 WALBROOK AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic coma — Unknown

DUE TO

(B) Underlying Infection (Urinary tract)

DUE TO

(C) HAS CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 1 19 66 to Jan 3 19 67. that (I) (we) last saw the deceased alive on Jan 3 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.
23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/6/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: WM MARCH ADDRESS: 928 E North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-615

67 0068

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0068

1. NAME OF DECEASED (Type or Print): Beverly Ann Ervin

2. DATE AND HOUR OF DEATH: 1/3/67 Noon M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Balt

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 405 Gwynn Ave

20-07

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 2/8/45

9. AGE (In years last birthday): 21

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical

10B. KIND OF BUSINESS OR INDUSTRY: Bank

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willy Erwin S/A

14. MOTHER'S MAIDEN NAME: Hazel Reed (Dec)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: 218-42-1754

17. INFORMANT: Willie Ervin 405 Gwynn Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

330 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sub-arachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/2/67 1967 to 1/3 1967, that (I) (we) last saw the deceased alive on 1/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: James E Arnold M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/3/67

23C. PHYSICIAN'S NAME (Type): James Arnold M.D.

23D. ADDRESS: Univ. Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/1967

24C. NAME OF CEMETERY or CREMATORY: Mt Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fabiano

25C. FUNERAL DIRECTOR: Williams Funeral Home

ADDRESS: 3198 W. Schroeder St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0069 Registered No. 67 0069

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SHERIDAN, ELIZABETH M.

2. DATE AND HOUR OF DEATH: Jan. 3 - 10 '67 7 05 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE UNION MEMORIAL HOSPITAL 33RD AND CALVERT ST., BALTIMORE, MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): BROADVIEW APT., 83K UNIVERSITY PARKWAY

12-01

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	WHITE	MARRIED	9/18/86	80		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: UNKNOWN Barron

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Wilford Sheridan

ADDRESS: 17 Blythewood Road Baltimore, Maryland 10

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) HEART FAILURE — 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) POSS. CEREBRAL HEMORRHAGE — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 2 1967 to JAN 3 1967, that (I) (we) last saw the deceased alive on JAN 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): FRANCIS W. GLUCK M.D.

23D. ADDRESS: 100 WEST UNIVERSITY PARKWAY, 10

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/67	New Cathedral Cemetery	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 5 1967	Robert E. Farley	Wm. J. Fickner & Sons	Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6 23

67 0070

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0070

1. NAME OF DECEASED (Type or Print): Martha D. Bright

2. DATE AND HOUR PRONOUNCED DEAD: 1/3/67 3:25 a.m. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1308 John St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 102

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1308 John St.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: Dec. 29, 1911

9. AGE (In years lost birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junion Partner

10B. KIND OF BUSINESS OR INDUSTRY: Balto. Photo and Blue Print Company

11. BIRTHPLACE (State or foreign country): Nashville, Tennessee

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Douglas Bright

14. MOTHER'S MAIDEN NAME: Lillian B. Halsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. James C. Halsey

ADDRESS: 521 Carolina Ave. Virginia Beach, Va.

MEDICAL CERTIFICATION

1B. 490X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): partial

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ Partial and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Cremation

23B. DATE: 1/5/1967

23C. NAME of CEMETERY or CREMATORY: Green Mount Crematory

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR: Robert E. Fahey

24C. FUNERAL DIRECTOR: Wm. J. Tickner & Sons

ADDRESS: Balto. Md. Northern

VS 151-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0071 Registered No. 67 0071

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Albert E. Blashfield

2. DATE AND HOUR OF DEATH: Jan. 3, 1967 12 30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MICHIGAN
B. COUNTY: MONTGOMERY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ANN ARBOR
D. STREET ADDRESS (If rural, give location): 1512 MORTON AVE.

V-19

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED.
8. DATE OF BIRTH: 1-28-1902
9. AGE (In years last birthday): 64
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dayton, Ohio
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ALBERT BLASHFIELD
14. MOTHER'S MAIDEN NAME: MARGARET Atherton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Gladys Blashfield
ADDRESS: same address

MEDICAL CERTIFICATION

18. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — 1 day
DUE TO
(B) ASCVD — years
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING ~~CAUSES OF DEATH~~?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/23 19 66 to 1/3 19 67, that (I) (we) last saw the deceased alive on 1/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Franklin G. Strauss M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): Franklin G. Strauss M.D.
23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/3/1967
24C. NAME of CEMETERY or CREMATORY: Washtenong Cemetery
24D. LOCATION (City, town, or county) (State): Ann Arbor, Michigan

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Wm. P. Fulton & Sons
ADDRESS: Balto., Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-42

122 67 330 BLASHFIELD, ALBERT

N-400

BIRTH NO. 67 0072

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0072

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Clarice Noel

2. DATE AND HOUR OF DEATH: January 1, 1967 | 10 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Wesley Home, Inc. 2211 W. Rogers Avenue Baltimore, Maryland 21209

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

2-2-15

D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave. 21209

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Aug. 23, 1877

9. AGE (In years last birthday): 89

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Trenton, N. J.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Palmer

14. MOTHER'S MAIDEN NAME: Rebecca Snyder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 220-48-3153 J

17. INFORMANT: The Wesley Home, Inc. ADDRESS: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this~~ hospital) attended the deceased from 7 September 1966 to 1 January 1967, that (I) (~~we~~) last saw the deceased alive on 30 December 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (~~I~~) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John W Barnaby M.D. Attending Phys. ☐ Med. Director ☒ Staff Phys. ☐

23B. DATE SIGNED: 3 Jan 67

23C. PHYSICIAN'S NAME (Type): JOHN W BARNABY M.D.

23D. ADDRESS: 1531 E North Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/1967

24C. NAME of CEMETERY or CREMATORY: First Presbyterian Cemetery

24D. LOCATION (City, town, or county) (State): Ewing, N. J.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: John J. Tuttner & Sons

ADDRESS: Balto. Md. North & Pa.

VS 150-REV. 1/1/65

B-525

BIRTH NO. 67 0073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0073

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sadie Adelle Benson

2. DATE AND HOUR OF DEATH: January 1, 1967 | 9:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Wesley Home, Inc. 2211 West Rogers Avenue Baltimore, Maryland 21209

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2211 West Rogers Ave. 21209

37-15

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Singel	Feb. 7, 1876	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Worked

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Davis Benson

14. MOTHER'S MAIDEN NAME: Hannah Jane Kelley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-22-4397 J-1

17. INFORMANT: The Wesley Home, Inc. ADDRESS: same address

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 16 January 19 66 to 1 January 19 67, that (I) (we) last saw the deceased alive on 30 December 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John W Barnaby M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 3 Jan 67

23C. PHYSICIAN'S NAME (Type): JOHN W BARNABY M.D.

23D. ADDRESS: 1531 E North Ave

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/4/1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. J. Tirbenet Sons ADDRESS: Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-453

Calvert Co. Md.

BIRTH NO. 67 0074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0074

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TIMOTHY HOLLAND

2. DATE AND HOUR OF DEATH: 1/1/67 7:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Maryland, Calvert Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Sunderland. 34-00

D. STREET ADDRESS (If rural, give location):

5. SEX: M

6. RACE: C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 3/29/66

9. AGE (In years last birthday): If Under 1 Yr. Months: 9 Days: 1 Hours: Min.: If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: RUSSELL HOLLAND, SR.

14. MOTHER'S MAIDEN NAME: THERESA SMITH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Theresa Smith ADDRESS: Sunderland -Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

(B) PNEUMONIA + RENAL Failure — 2-4 day

DUE TO

(C) DEHYDRATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 29 19 66 to JANUARY 1 19 67, that (I) (we) last saw the deceased alive on JANUARY 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S DuBose Ravenel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): SAMUEL DUBOSE RAVENEL M.D.

23D. ADDRESS: Box 51 JOHNS HOPKINS HOSPITAL BALTIMORE MD.

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 1-3-67

24C. NAME of CEMETERY or CREMATORY: Mt. Hope C. C.

24D. LOCATION (City, town, or county) (State): Sunderland- Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fabian

25C. FUNERAL DIRECTOR: Pinkney & Sewell - Prince Fred. Md.

ADDRESS:

VS 150-REV. 1/1/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-350

BIRTH NO. 67 0075

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0075

1. NAME OF DECEASED (Type or Print): Thomas C. Rodney

2. DATE AND HOUR OF DEATH: 1-1-67 7:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-03
D. STREET ADDRESS (If rural, give location): 873 N. Howard St.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2-22-86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Thomas Rodney
14. MOTHER'S MAIDEN NAME: Henrietta Urie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT: Patient chart ADDRESS

MEDICAL CERTIFICATION

18. 493X1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia — 48 hr ?
DUE TO
(B) Congestive Heart failure — 48 hr ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12-31 1966 to 1-1 1967, that ~~(I)~~ (we) last saw the deceased alive on 1-1 1966 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John R. Vaughn Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-1-67
23C. PHYSICIAN'S NAME (Type): JOHN R. VAUGHN, JR M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN. 4
24C. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
24D. LOCATION (City, town, or county) (State): Rock Hall MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: Edgar L. Lane
ADDRESS: Church Hill Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-206

BIRTH NO. 67 0076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0076

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TOWANDA CAGE

2. DATE AND HOUR OF DEATH: JAN. 3, 67 | 2:00 AM PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md GEN HOSPITAL

48 BALTO., Md 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 11-02

D. STREET ADDRESS (If rural, give location): 1218 St Paul St.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED

8. DATE OF BIRTH: 09/20/20

9. AGE (In years last birthday): 46

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESLADY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ERNEST RHEA

14. MOTHER'S MAIDEN NAME: CATHERINE MAUPKIN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 224-16-0616

17. INFORMANT: KENNETH R. KOSKINEN M.D.

ADDRESS

MEDICAL CERTIFICATION

18. 416 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Rheumatic Heart disease / mitral

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/22 19 66 to 1/3 19 67, that (I) (we) last saw the deceased alive on 1/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Koskinen, M.D. (Kenneth C. Wilk)

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/3/67

23C. PHYSICIAN'S NAME (Type): Daniel C Wilkerson M.D.

23D. ADDRESS: 421 Register Ave Balto 12

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: Meadowridge

24D. LOCATION (City, town, or county) (State): Elkridge Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fahrner

25C. FUNERAL DIRECTOR: McCully F H

ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

M-324

67 0077

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0077

1. NAME OF DECEASED (Type or Print): NOAH MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 8:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1833 N. Montford Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 802

D. STREET ADDRESS (If rural, give location): 1833 N. Montford Avenue

5. SEX: Male

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: Dec. 23, 1906

9. AGE (In years last birthday): 60

If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Mitchell

14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Omer Malone ADDRESS: Same

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-7-67

23C. NAME of CEMETERY or CREMATORY: Arbutus Cem

23D. LOCATION (City, town, or county) (State): Lanvale Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR: R. Bert E. Fairbanks

24C. FUNERAL DIRECTOR: Elroy O. Wilson

ADDRESS: 1000 Brantleigh

VS 151-REV. 1/1/65

M-625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 8-4-13 67 0078 Registered No. 67 0078

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (Morgan) Morgan Emma V.

2. DATE AND HOUR OF DEATH 1-4-67 @ 5:30 p.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland general hospital Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md B. COUNTY ~~A~~ Baltimore #12

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27.48

D. STREET ADDRESS (If rural, give location) 724 Beaverbrook Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	S	8/4/13	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel morgan

14. MOTHER'S MAIDEN NAME Sadie Kelly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No

16. SOCIAL SECURITY NO. 212 07 0663

17. INFORMANT Mrs. Sister: John Boegner ADDRESS 2814 Evergreen Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 5-6 months

DUE TO

(B) Heart lung failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. lungs metastasis

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/28/ 1966 to 1/4 1967, that (I) (we) last saw the deceased alive on 1/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Awaye M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐ House Phys.

23B. DATE SIGNED 1/4/67

23C. PHYSICIAN'S NAME (Type) Abdelgaffar Awaye M.D.

23D. ADDRESS University hospital Balt.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/7/67.

24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 5 1967

25B. NAME OF REGISTRAR Robert E. Fallaya

25C. FUNERAL DIRECTOR Leonard J. Rack, Inc. ADDRESS Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

F-620

BIRTH NO. 67 0079

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0079

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANCES FREESE

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 | 10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-03

D. STREET ADDRESS (If rural, give location): 427 N. Maderia Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Jan. 5, 1903

9. AGE (In years last birthday): ~~63~~ 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assembler

10B. KIND OF BUSINESS OR INDUSTRY: Edgewood Arsenal

11. BIRTHPLACE (State or foreign country): Newport News, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John William Hopkins

14. MOTHER'S MAIDEN NAME: Diana Frances Furgeson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-24-4060

17. INFORMANT: Mrs. Arlene Freeburger ADDRESS: 904 S. Curley

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

1B. 443X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/7/67

23C. NAME of CEMETERY or CREMATORY: Bakers Cemetery

23D. LOCATION (City, town, or county) (State): Aberdeen, Harford Co. Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR: Robert E. Fasbender

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks ADDRESS: 1217 St. Paul St.

VS 151-REV. 1/1/65

R-524 1

BIRTH NO. 67 0080

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0080

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Rinkle, Mary

2. DATE AND HOUR OF DEATH: 1-4-67 | 12:15 A.m. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital. 423

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore. 24-01
D. STREET ADDRESS (If rural, give location): 1404 Cookie St. 730.

5. SEX: F.
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 7-6-96
9. AGE (In years last birthday): 70
If Under 1 Yr. Months / Days | If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packing House
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Rinkle
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-10-8067
17. INFORMANT: Mildred Goodwin
ADDRESS: 1404 Cookie St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — 1 hour
DUE TO
(B) Chronic Hypertensive — years
DUE TO
(C) Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that ~~I~~ (this hospital) attended the deceased from Jan 3 1967 to Jan 4 1967, that (I) (~~we~~) last saw the deceased alive on Jan 4 1967 and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-4-67
23C. PHYSICIAN'S NAME (Type): John J. Conroy M.D.
23D. ADDRESS: S. Balto. Gen. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/67
24C. NAME of CEMETERY or ~~CREMATORY~~: Holy Cross Cemetery
24D. LOCATION (City, town, or county) (State): Anne Arundel, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Charles L. Stevens
ADDRESS: Stevens Funeral Home, Inc. 1501 E. Fort Avenue

VS 150-REV. 1/1/65

M-250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0081 Registered No. 67 0081

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mollie M. McCann

2. DATE AND HOUR OF DEATH: Jan 2, 1967 8:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convelasarium

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-06

D. STREET ADDRESS (If rural, give location): 2413 Maryland Avenue 21218

5. SEX: F

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Feb 14, 1881

9. AGE (In years last birthday): 85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George Reiggle

14. MOTHER'S MAIDEN NAME: Wisner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No.

(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO. 218-18-3312-K1

17. INFORMANT: James Litzinger ADDRESS: 901 W. 38th St. 21211

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 4 20.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic cardiac disease — INTERVAL BETWEEN ONSET AND DEATH: several yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. glaucoma — 1½ yrs.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-10- 19 51 to Jan 2, 19 67, that (I) (we) last saw the deceased alive on 10-31- 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E Ellsworth Cook M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-4-67

23C. PHYSICIAN'S NAME (Type): E. ELLSWORTH COOK M.D.

23D. ADDRESS: 2431 MARYLAND AVE. BALTO Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 5, 1967

24C. NAME of CEMETERY or CREMATORY: St. Marys (Hampden)

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Frank W. Leitz ADDRESS: 814 W 36th St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-51 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0082 Registered No. 67 0082

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Allen Thompson

2. DATE AND HOUR OF DEATH: 1-3-1967 | 12:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #212324-03
D. STREET ADDRESS (If rural, give location): 1418 Battery Ave.

5. SEX: M
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEP.
8. DATE OF BIRTH: 9-12-1894
9. AGE (In years last birthday): 72
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank
14. MOTHER'S MAIDEN NAME: Greta Rolfson.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: FAMILY - JAMES
ADDRESS

MEDICAL CERTIFICATION

1B. 0 3 3 4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

(A) ASPIRATION PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

(B) SEPSIS — 7

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-27 1966 to 1-3 1967, that (I) (we) last saw the deceased alive on 1-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-3-1967

23C. PHYSICIAN'S NAME (Type): Harold A. Burnham M.D.
23D. ADDRESS: 1213 Light St.

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 1 5 67
24C. NAME of CEMETERY or CREMATORY: Glen Ephrata
24D. LOCATION (City, town, or county) (State): Balto.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: R. Cathy
ADDRESS: 1306 Fort Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-650

BIRTH NO. 67 0083

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0083

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PHILLIP B. MARIANO

2. DATE AND HOUR PRONOUNCED DEAD: January 3, 1967 10:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Union Memorial Hospital 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-38

D. STREET ADDRESS (If rural, give location): 1548 Wadsworth Way

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	M.	5-27-38	28	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Elec. Eng.	Western Elec.	Md.	

13. FATHER'S NAME: Sebastiani

14. MOTHER'S MAIDEN NAME: Margaret Bartholomew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes. (If yes, give war or dates of service): 1962

16. SOCIAL SECURITY NO.

17. INFORMANT: Family - Jane ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E816.4

(A) Crushed Chest

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Lock Raven Blvd. & The Alemeda 9-02

21D. TIME OF INJURY (APPROX.): (Month) 1 (Day) 3 (Year) '67 (Hour) 10:20 P.M.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Auto-auto Accident - Deceased was Driver

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
B.	1/7/67	Holly Hill	Baltimore

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 5 1967	Robert E. Farbaugh	H. C. Gray	130 E. Fort Av.

VS 151-REV. 1/1/65

N862.2

M-164

BIRTH NO. 67 0084

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0084

1. NAME OF DECEASED (Type or Print): MOBERLY MARION ERNEST

2. DATE AND HOUR OF DEATH: JAN 3 1967 7:13 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: A.A. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 52-00

D. STREET ADDRESS (If rural, give location): 112 OLAN DRIVE 21061

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-17-09

9. AGE (In years last birthday): 57

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ASST FOREMAN

10B. KIND OF BUSINESS OR INDUSTRY: Balto. Gas & Elec.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ERNEST Moberly

14. MOTHER'S MAIDEN NAME: ALICE Anderson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212 05 3404

17. INFORMANT: Hilda Moberly, wife, above ADDRESS: ST AGNES HOSPITAL CATON & WILKENS AVE.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 33/X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest

DUE TO

(B) CVA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 1 19 67 to JAN 3 19 67, that (I) (we) last saw the deceased alive on JAN 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A B Hooton M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-3-67

23C. PHYSICIAN'S NAME (Type): A. B. HOOTON M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0085 Registered No. 67 0085

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SNELL, Mary O.

2. DATE AND HOUR OF DEATH: January 3, 1967 | 8:25 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-01

D. STREET ADDRESS (If rural, give location): 3212 Elmora Avenue #13

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	married	12/30/92	74 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Henry Fischbach

14. MOTHER'S MAIDEN NAME: Elizabeth Appell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Leland Snell, husband, above — ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Occlusion — 15 minutes

DUE TO

(B) Hypertensive Vascular Disease — 10 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0	—	no.	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 15 1959 to January 3rd 1967, that (I) ~~(we)~~ last saw the deceased alive on 10/3/66 19 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: William M Conway M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): Dr. William M. Conway M.D.

23D. ADDRESS: 8358 Loch Raven Blvd.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/7/67	Gardens of Faith Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Charles E. Fahrney

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. — ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0086 X Registered No. 67 0086

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): APPELL, Mrs. Mary M.

2. DATE AND HOUR OF DEATH: Jan. 3, 1967 | 2:40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 JENKINS MEMORIAL HOSPITAL, 1000 S. CATON AVE., BALTO., MD 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 115 Hopkins Rd. 21212

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	White	Widowed	July 14, 1888	78 yrs		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SEAMSTRESS	CLOTHING BUSINESS (Seamstress)	Baltimore, Md	U S A

13. FATHER'S NAME: Joseph Kral

14. MOTHER'S MAIDEN NAME: Caroline Ruzicka

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 214 03 1837

17. INFORMANT: Irma G. Kraft, 113 Hopkins Rd., neice — ADDRESS: M. Kohler- Medical Records- Jenkins Mem'l

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
260 X	(A) Acute myocardial infarction	1 day
	DUE TO (B) Pernicious Anemia	years
	DUE TO (C) Diabetes Mellitus	years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-15 1966 to 1-5 1967, that (I) (we) last saw the deceased alive on 1-5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-5-67

23C. PHYSICIAN'S NAME (Type): MANUEL RODRIGUEZ M.D.

23D. ADDRESS: 1424 Sulphur Spr. Rd-Arbutus

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. — ADDRESS: 3331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

B-650

BIRTH NO. 67 0087

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0087

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT E. BOEREN

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 | 3:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 3311 Kenyon Avenue #13

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: April 15, 1930

9. AGE (In years last birthday): 36

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Policeman

10B. KIND OF BUSINESS OR INDUSTRY: City of Balto.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert J. Boeren

14. MOTHER'S MAIDEN NAME: Dolores Schumann (nee Smoot)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Marjorie Boeren, wife, above

ADDRESS

MEDICAL CERTIFICATION

18. 420.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/7/67

23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State): Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

24B. NAME OF REGISTRAR: Robert E. Fairbanks

24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 3331 Brehms Lane #13

0 0 8 8

VS 151-REV. 1/1/65

H-20

S530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0088 Registered No. 67 0088

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): House, SMITH, ELSIE.

2. DATE AND HOUR OF DEATH: 1/3/67 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 808 St. Paul Street

1-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Single	9/23/11	55		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen Smith
14. MOTHER'S MAIDEN NAME: Alice Demby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Alice Fulghun ADDRESS: 1346 W. Mosher St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMATOSIS — ca. 3 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3 1967 to 1/3 1967, that (I) (we) last saw the deceased alive on 1/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sherard P. Hayes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): Sherard Hayes M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-7-67	Mount Auburn Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967
25B. NAME OF REGISTRAR: Robert E. Fulton
25C. FUNERAL DIRECTOR: Horton & Dyett F.H.
ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-62-6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO. 67 0089

Registered No. 67 0089

1. NAME OF DECEASED (Type or Print): EDNA SCHOFIELD BROOKS

2. DATE AND HOUR OF DEATH: January 3, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1410 N. Bruce Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-02

D. STREET ADDRESS (If rural, give location): 1410 N. Bruce Street

5. SEX: F.

6. RACE: N.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 6-21-1908

9. AGE (In years last birthday): 58

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS FELLS

14. MOTHER'S MAIDEN NAME: REBECCA FELLS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-09-5085

17. INFORMANT: Miss Birdie Brooks ADDRESS: 1410 Bruce St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Aug 1966 to Dec 20 1966, that (I) (~~we~~) last saw the deceased alive on Dec 20 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Royston B. Sam M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: JAN 4, 67

23C. PHYSICIAN'S NAME (Type): ROYSTON B SAM M.D.

23D. ADDRESS: 1801 W Baltimore St Baltimore (21)

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-7-67

24C. NAME of CEMETERY or CREMATORY: Mount Calvary Cem.

24D. LOCATION (City, town, or county) (State): A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Fowler

25C. FUNERAL DIRECTOR: Morton & Dyett F.H. ADDRESS: 1701 Laurens St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Medical Exam Office called for

1
0-236
0-236

67 0090

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0090

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Osterholtz William P. Osterholz

2. DATE AND HOUR PRONOUNCED DEAD: 1/3/67 12:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1287 Williams St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-03

D. STREET ADDRESS (If rural, give location): 1287 Williams St.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9-25-11

9. AGE (In years last birthday): 55

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10B. KIND OF BUSINESS OR INDUSTRY: Black & Decker

11. BIRTHPLACE (State or foreign country): Savannah, Ga.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles Osterholtz

14. MOTHER'S MAIDEN NAME: Anna Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-03-4992

17. INFORMANT: Mrs. Bessie Osterholtz

ADDRESS: 1287 William St. 30

MEDICAL CERTIFICATION

18. 490 X

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fatty alteration of liver

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): partial

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-6-67

23C. NAME of CEMETERY or CREMATORY: Glen Haven Cemetery

23D. LOCATION (City, town, or county) (State): Ritchie Hwy. Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

24B. NAME OF REGISTRAR: Robert E. Farley

24C. FUNERAL DIRECTOR: Flynn & Fleming

ADDRESS: Flynn & Fleming, 1422 Light St.

VS 151-REV. 1/1/65

L-120 1

BIRTH NO. 67 0091

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0091

1. NAME OF DECEASED (Type or Print): John Whittington Lips

2. DATE AND HOUR OF DEATH: January 2, 1967 | 4:50 p.m.

CERTIFICATE AMENDED 1-13-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4203 Penhurst Avenue Balto. 15, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore County
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Baltimore~~ - Pikesville
D. STREET ADDRESS (If rural, give location): ~~4203 Penhurst Ave. --- 21215~~ 417 Upland Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	Nov. 27, 1885	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Central Office repair	C&P Telephone Co	Balto. Md.	U.S.A.

13. FATHER'S NAME: John Lips

14. MOTHER'S MAIDEN NAME: Katherine Armitage Coyle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-03-6691

17. INFORMANT: Mrs. Emily L. Morgan ADDRESS: 417 Upland Rd Pikesville 8, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
331 X		
(A) DUE TO	Cerebral vascular accident lt Hemiplegia	5 days
(B) DUE TO	Hypertension	Few years -
(C)		

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 19 56 to Jan 2 1967, that (I) (~~we~~) last saw the deceased alive on Jan 2 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Paul H Royse M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan 4, 1967

23C. PHYSICIAN'S NAME (Type): Paul H. Royse M.D.

23D. ADDRESS: 1403 Foley Lane Pikesville 8 Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1/5/67	Druid Ridge	Pikesville 8	Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Irving Byers ADDRESS: 8728 Liberty Rd Randallstown Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530

BIRTH NO. 67 0092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0092

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILDRED S. SMITH

2. DATE AND HOUR OF DEATH: 1/3/67 4:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL of MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): English Consul 53-00
D. STREET ADDRESS (If rural, give location): 3018 Pennsylvania Avenue

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 8/27/04
9. AGE (In years last birthday): 62
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry M. Sawyer
14. MOTHER'S MAIDEN NAME: Margaret Bell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 214-14-8227
17. INFORMANT: Mr. Elmer C. Smith, 3018 Pennsylvania Ave. ADDRESS 21227

MEDICAL CERTIFICATION

1B. 422.1 I 260 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ACUTE MYOCARDIAL INFARCTION (HOURS)
DUE TO
(B) ARTERIO SCLEROTIC CARDIOVASCULAR
DUE TO
(C) DISEASE (YEARS)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: DIABETES MELLITUS

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/24 19 66 to 1/3 19 67, that (I) (we) last saw the deceased alive on 1/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Oscar E. Fernandini M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): OSCAR E. FERNANDINI M.D.
23D. ADDRESS: Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-67
24C. NAME of CEMETERY or CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Farber
25C. FUNERAL DIRECTOR: Howard H. Hubbard
ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0093 Registered No. 67 0093

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) LAMARTINA MARY (Mary LaMartina)

2. DATE AND HOUR OF DEATH 1/3/67 3:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp.

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-17

D. STREET ADDRESS (If rural, give location) 5330 - WINNER AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	W	MARRIED	5-15-02	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE		Baltimore, Md.	

13. FATHER'S NAME Charles Cox

14. MOTHER'S MAIDEN NAME unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Hosp. Rec.	

MEDICAL CERTIFICATION

1B. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) C.V.A. DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/24 19 66 to 1/3 19 67, that (I) (we) last saw the deceased alive on 1/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE S. Gordon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 1/3/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS Sinai Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/6/1967	Cathedral Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 6 1967	Robert E. Fisher	B. Vernon Leaman	4611 Park Heights Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-600

BIRTH NO. 67 0094

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0094

1. NAME OF DECEASED (Type or Print): SCHAAR, WALTER A

2. DATE AND HOUR OF DEATH: JANUARY 3, 1967 | 6:35 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location)

ST. AGNES HOSPITAL
CATON AND WILKENS AVENUES
BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21228 Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 5445 WILKENS AVENUE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 9-20-90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALOIS SCHAAR DEC'D

14. MOTHER'S MAIDEN NAME: CATHERINE (KRAMER) DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOSPITAL SLIP-ST. AGNES HOSPITAL ADDRESS

MEDICAL CERTIFICATION

1B. 422.1 + 260X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) A.S.C.V.D.

DUE TO

(B) C. V. A.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus – Gout

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that X (this hospital) attended the deceased from JANUARY 2, 1967 to JANUARY 3, 1967, that X (we) last saw the deceased alive on JANUARY 3, 1967 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X (We) (did) (did not) view the body after death.

23A. SIGNATURE: E.W.Weiss M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 1/03/67

23C. PHYSICIAN'S NAME (Type): E.W.WEISS M.D.

23D. ADDRESS: BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON & WILKES AVES

24A. BURIAL CREMATION, REMOVAL (Specify): ENTOMBMENT

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: LORRAINE PARK

24D. LOCATION (City, town, or county) (State): BALTO. CO. MD

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: E. G. MALNABB

ADDRESS: 301 FREDERICK Rd 21228

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0095 Registered No. 67 0095

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Stein

2. DATE AND HOUR OF DEATH: January 1, 1967 | 6:25 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 6114 Biltmore Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 6114 Biltmore Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: May 1, 1891
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Gustav Pick
14. MOTHER'S MAIDEN NAME: Rosa Nalos
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Susanne Glaser, ADDRESS: 6114 Biltmore Avenue

MEDICAL CERTIFICATION

1B. 1 3 4 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Recurrent carcinoma, rectum with metastasis — 3 months
DUE TO
(B) carcinoma rectum - abdominal perineal resection - colostomy — 3 years
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct 1963
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: carcinoma rectum
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1957 to Jan 1 1967, that (I) (we) last saw the deceased alive on Dec. 30th 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold H. Bix M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Jan 20th 1967
23C. PHYSICIAN'S NAME (Type): Dr. Harold Bix M.D.
23D. ADDRESS: 1401 Reisterstown Road

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/3/67
24C. NAME of CEMETERY or CREMATORY: Mt. Moriah
24D. LOCATION (City, town, or county) (State): New Jersey

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0096 Registered No. 67 0096

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Baum, Minnie [redacted]

2. DATE AND HOUR OF DEATH: Jan. 1, 1967 | 4 00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): 3209 Northmont Rd.

5. SEX: Fe.
6. RACE: Cauc.
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1917 [redacted]
9. AGE (In years last birthday): 49
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathan Erkes
14. MOTHER'S MAIDEN NAME: Annie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-14-4417
17. INFORMANT: Mr. Kenny Baum, ADDRESS: 3209 Northmont Road #9

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 795.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure — 5 days

DUE TO

(B) Poly cystic kidneys. — congenital

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No. —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/12 1966 to 1/1 1967, that (I) (we) last saw the deceased alive on 1/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Erwin H. Hesselberg M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/1/67
23C. PHYSICIAN'S NAME (Type): Erwin H. Hesselberg M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/2/67
24C. NAME of CEMETERY or CREMATORY: Shaarei Zion
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Tarbeyna
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reist. Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-5 326

BIRTH NO. 67 0097

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0097

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and, the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HANDWERGER FRANK

2. DATE AND HOUR OF DEATH: 1/2/67 1 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 28-31

D. STREET ADDRESS (If rural, give location): 5411 Lynnview Av

5. SEX: Male

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12/25/98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Balto., City Employee

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Handwerger

14. MOTHER'S MAIDEN NAME: Eva ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-8697

17. INFORMANT: Mrs. Edith Handwerger, 5411 Lynnview Avenue

ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: MYOCARDIAL INFARCT — DAYS

(B) DUE TO: ASCVD — YEARS

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/26 1966 to 1/2 1967, that (I) (we) last saw the deceased alive on 1/2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stephen Gordon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/2/67

23C. PHYSICIAN'S NAME (Type): Stephen Gordon M.D.

23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/3/67

24C. NAME of CEMETERY or CREMATORY: Hebrew Young Mens

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

25B. NAME OF REGISTRAR: Robert E. Fabian

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

T-255

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased priar to death); and (6) No physician was in regular attendance on the deceased priar to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0098

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0098

1. NAME OF DECEASED (Type or Print): LOUIS TEICHMAN

2. DATE AND HOUR OF DEATH: JAN. 5, 1967 | 9 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospitol or institution, give street address or location): 00

144 N. DECKER AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: BALTO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 6-01

D. STREET ADDRESS (If rural, give location): 144 N. DECKER AVE.

5. SEX: M.

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: MAR. 13, 1884

9. AGE (In years last birthday): 82

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: — — — — — — — — — —

14. MOTHER'S MAIDEN NAME: — — — — — — — — — —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS ANNA TEICHMAN

ADDRESS: 144 N DECKER AVE

MEDICAL CERTIFICATION

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) Coronary Artery Occlusion	1/2 hour
DUE TO	
(B) Arteriosclerosis, Cardiovascular Disease	Unknown
DUE TO	
(C) Pernicious Anemia	Unknown

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (~~this hospital~~) attended the deceased from January 7 1966 to Jan. 5 1967, that (I) (~~we~~) last saw the deceased alive on January 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Philibert Artigiani M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): Philibert Artigiani M.D.

23D. ADDRESS: 2305 Mayfield Ave. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-7-67

24C. NAME of CEMETERY or CREMATORY: OAKLAWN CEMETERY

24D. LOCATION (City, town, or county) (State): BALTO. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: B. DeBROWSKI

ADDRESS: 2818 E. BALTIMORE ST.

VS 150-REV. 1/1/65

1

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0099 Registered No. 67 0099

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Louise A. Peterson (Petterson)

2. DATE AND HOUR PRONOUNCED DEAD 1/3/67 5:55 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 901

D. STREET ADDRESS (If rural, give location) 3959 Greenmount Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
female	white	Widowed	10/3/1896	70	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	N. C.	U.S.A.

13. FATHER'S NAME Carl C. Morck

14. MOTHER'S MAIDEN NAME Helen McArdle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-20-4781

17. INFORMANT Mrs. William Hall ADDRESS (Same)

MEDICAL CERTIFICATION

18. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/7/1967	Holy Cross	Ritchie Hywy.A.A.Co., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 6 1967	Robert E. Fahrney	H.W.Jenkins & Sons Co.	4905 York Rd. Baltimore 12, Md.

00098

VS 151-REV. 1/1/65

S-400 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0100 Registered No. 67 0100

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Beta Schley

2. DATE AND HOUR OF DEATH: Jan. 4, 1967 | 2:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Ardleigh Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 902
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1502 Tunlaw Road

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 9/28/1878
9. AGE (In years last birthday): 88
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Dorothea Pundt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -D: 220-07-1925
17. INFORMANT: Mrs. Dorothy L. Collison
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A)	Arteriosclerotic cardio-vascular disease	15 yrs.
DUE TO (B)	Cerebral thrombosis	2 mo.
DUE TO (C)	Mild diabetes	1 yr.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from December 27, 1966 to January 4, 1967, that (I) (~~we~~) last saw the deceased alive on January 3, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D.
Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/5/1967.
23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.
23D. ADDRESS: 3902 Greenmount Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/1967
24C. NAME of CEMETERY or CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Talley M.D.
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-1001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0101
M.E. CASE NO.

Registered No. 67 0101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): EMMA R. Love

2. DATE AND HOUR OF DEATH: 1-4-67 2:00P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 903
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3509 Greenmount Ave.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 9/23/1896
9. AGE (In years last birthday): 70
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Frederick, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles E. Zellers
14. MOTHER'S MAIDEN NAME: Mary Baer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-05-0356D
17. INFORMANT: Kenneth C. Love, Jr.
ADDRESS: 5815 Leith Walk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Irreversible Shock — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(B) Coronary Thrombosis
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-4 1967 to 1-4 1967, that (I) (we) last saw the deceased alive on 1-4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank L. Barham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-4-67
23C. PHYSICIAN'S NAME (Type): FRANK L. BARHAM M.D.
23D. ADDRESS: Mercy Hospital Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/1967
24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Park
24D. LOCATION (City, town, or county) (State): Parkville, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

S-5301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0102 Registered No. 67 0102

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): R. Neale Smith

2. DATE AND HOUR OF DEATH: January 5, 1967 | 10:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(If not in hospital or institution, give street address or location): 6202 Blackburn Lane

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 27-12

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 6202 Blackburn Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	5/6/1888	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Phila.Pa.	Electric Co.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Aloysius Carroll Smith

14. MOTHER'S MAIDEN NAME: Ella Meek

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	164-05-1303	Mrs. Blanche W. Smith	(Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C) Arteriosclerotic Heart Disease — 5 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1958 19 to 1/5/ 19 67, that (I) (~~we~~) last saw the deceased alive on 12/4/ 19 66 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert T. Parker M.D. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/5/1967

23C. PHYSICIAN'S NAME (Type): ROBERT T. PARKER M.D.

23D. ADDRESS: SOUTH BALTO GEN HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/7/1967	New Cathedral	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 6 1967	Robert E. Lackey M.D.	H.W. Jenkins & Sons Co.	4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-42b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0103 Registered No. 67 0103

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Realce Pedro

2. DATE AND HOUR OF DEATH: January 4th 1967 5.30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION: Sinai Hospital of Baltimore Inc (If not in hospital or institution, give street address or location)

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-02
D. STREET ADDRESS (If rural, give location): 1802 N. Mount St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	N	M	5/5/04	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Phillipines
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CEFERINA REALCE
14. MOTHER'S MAIDEN NAME: APALONIA REA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 317-22-7721
17. INFORMANT: MARY F. REALCE — ADDRESS: 1802 MOUNT STREET

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undifferentiated Carcinoma — Unknown

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — White At Work ☐ Not White At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 3 1967 to Jan 4th 1967, that (I) (we) last saw the deceased alive on Jan 4th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Cieplinski M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/4/67
23C. PHYSICIAN'S NAME (Type): William Cieplinski M.D.
23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-67
24C. NAME of CEMETERY or CREMATORY: ARBUTUS MEM. PK.
24D. LOCATION (City, town, or county) (State): ARBUTUS, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: R. L. B. E. Faulkner
25C. FUNERAL DIRECTOR: GEORGE KELSON — ADDRESS: 1348 CALHOUN ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
R-360

67 0104

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0104

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGIA HENDERSON Reeder

2. DATE AND HOUR PRONOUNCED DEAD: January 3, 1967 7:58 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1043 Harlem Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01

D. STREET ADDRESS (If rural, give location): 1043 Harlem Avenue

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 4-27-08

9. AGE (In years last birthday): 58

If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henderson

14. MOTHER'S MAIDEN NAME: Daisy Russ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Estelle Thompson ADDRESS: 2439 Edmondson Ave,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E916.0

(A) Extensive Burns

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Acute ethylism

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1043 Harlem Avenue 16-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): About 1/3/67 in the P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Apparently clothing caught fire.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-7-67

23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park

23D. LOCATION (City, town, or county) (State): Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

24B. NAME OF REGISTRAR: Robert E. Fulton

24C. FUNERAL DIRECTOR: George Kelson ADDRESS: 1348 Calhoun St.

VS 151-REV. 1/1/65

N 948.2

1
D-250

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0105

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): George Dyson

2. DATE AND HOUR PRONOUNCED DEAD: 1/3/67 | 11:35 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 1930 McCulloh St.

5. SEX: male
6. RACE: colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): single
8. DATE OF BIRTH: 9-30-08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Dyson
14. MOTHER'S MAIDEN NAME: Grace Smallwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218056377
17. INFORMANT: Dorothy Newkirk ADDRESS: 1705 Payson Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

1B. 331 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive spontaneous intra-cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-7-67
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
23D. LOCATION (City, town, or county) (State): Arbutus, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: GEORGE KELSON ADDRESS: 1348 CALHOUN ST.

VS 151-REV. 1/1/65

1
L-536

67 0106

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0106

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THOMAS V. LANTIERI

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 2:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
35 Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-05
D. STREET ADDRESS (If rural, give location): 2124 Pratt Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: SEPT. 29, 1923
9. AGE (In years last birthday): 43
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ALPHONSE LANTIERI
14. MOTHER'S MAIDEN NAME: FRANCES FORTE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.:
17. INFORMANT: MIKE LANTIERI ADDRESS: 606 UMBRA ST

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 1B. 420.0 & 002.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Inactive Pulmonary Tuberculosis.

19A. DATE OF OPERATION: 24
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Charles S. Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 1-9-66
23C. NAME of CEMETERY or CREMATORY: BALTO. NATIONAL CEM.
23D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

24A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: JOHN M. WEBER & SONS INC.
ADDRESS: 401 S. CHESTER ST.

VS 151-REV. 1/1/65

H-40

C-200

BIRTH NO. 67 0107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0107

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) CHASE, KATIE M. (HALL)

2. DATE AND HOUR OF DEATH 1/5/67 1:00 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

46

LUTHERAN HOSPITAL OF MARYLAND 1916 W. SARATOGA STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE

D. STREET ADDRESS (If rural, give location) 20-01

5. SEX FEMALE

6. RACE NEGRO

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED

8. DATE OF BIRTH 4-9-33

9. AGE (In years last birthday) 33

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Washington, GA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Tomie HALL

14. MOTHER'S MAIDEN NAME Luella Bates

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-96-5363

17. INFORMANT Tomie HALL

ADDRESS 1916 W Saratoga St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 157X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE PULMONARY EMBOLISM

DUE TO

(B) THROMBOPHLEBITIS

DUE TO

(C) PROBABLY CA. OF PANCREAS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 6 1966 to JAN 5 1967, that (I) (we) last saw the deceased alive on JAN 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Young Kil Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 1/5/67

23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM M.D.

23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-10-67

24C. NAME of CEMETERY or CREMATORY Baltimore National

24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 6 1967

25B. NAME OF REGISTRAR Robert E. Fankenhauser

25C. FUNERAL DIRECTOR Charles R. Law

ADDRESS 802 Madison Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-536

67 0108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0108

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WALTER H. SMITH

2. DATE AND HOUR OF DEATH: 1-2-67 | 12.55A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-01

D. STREET ADDRESS (If rural, give location): 1439 N. CAREY STREET

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 1-11-82

9. AGE (In years last birthday): 84

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOSEPH SMITH

14. MOTHER'S MAIDEN NAME: MATTIE BOOKMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-2959

17. INFORMANT: Hospital Records

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pericarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

DUE TO

(B) Probable Tuberculosis. — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-10 1966 to 1-2 1967, that (I) (we) last saw the deceased alive on 1-2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Carlton R. Hamilton Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-2-67

23C. PHYSICIAN'S NAME (Type): C.R. HAMILTON, JR. M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 5, 1967

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county): Arbutus (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Joseph L. Russ

ADDRESS: 2222 N. North Ave. Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-321

BIRTH NO. 67 0109

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0109

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): John Ritchie, Sr.

2. DATE AND HOUR OF DEATH: 1-4-1967 9:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Prince Geo.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Laurel (Snowden Oaks)
D. STREET ADDRESS (If rural, give location): 13113 Claxton Drive 66-00

5. SEX: M
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10-8-1921
9. AGE (In years last birthday): 45
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Anylist Computer
10B. KIND OF BUSINESS OR INDUSTRY: U.S.GOV'T
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ernest Ritchie
14. MOTHER'S MAIDEN NAME: Margaret Graham

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): W W II
16. SOCIAL SECURITY NO.: 216-16-8076
17. INFORMANT: Mrs. Ann Marie Ritchie
ADDRESS: Same as #4

MEDICAL CERTIFICATION

18. 722.01

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SEVERE RHEUMATOID ARTHRITIS — 8 YEARS
DUE TO
(B) ADRENAL INSUFFICIENCY — 8 YEARS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 12-14 1966 to 1-4 1967, that (we) last saw the deceased alive on 1-4 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-5-1967
23C. PHYSICIAN'S NAME (Type): Harold A. Burnham M.D.
23D. ADDRESS: 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Jan. 9, 1967
24C. NAME of CEMETERY or CREMATORY: ARLINGTON NATIONAL CEMETERY
24D. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Harold A. Cole
ADDRESS: 550 Main St., Laurel, Md.

VS 150-REV. 1/1/65

M-616

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0110 Registered No. 67 0110

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Benjamin F. Murphy

2. DATE AND HOUR OF DEATH: January 3, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 3503 Woodbrook Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Feb. 13, 1905
9. AGE (In years last birthday): 61
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin F. Murphy
14. MOTHER'S MAIDEN NAME: Etta Harper

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W W II
16. SOCIAL SECURITY NO.: 228-20-3302
17. INFORMANT: Mrs. Dorothy Murphy ADDRESS: 3503 Woodbrook Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — 1d
DUE TO
(B) Coronary Insufficiency — 2 years.
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-3- 1961 to 1-3- 1967, that (I) (we) last saw the deceased alive on 12-28- 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Percival C. Smith M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-5-67
23C. PHYSICIAN'S NAME (Type): Percival C. Smith M.D.
23D. ADDRESS: 1709 Gwynns Falls Pkwy

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-6-67
24C. NAME of CEMETERY or CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Arlington S. Phillips ADDRESS: 1727 N. Monroe Street

VS 150-REV. 1/1/65

H-65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0111 Registered No. 67 0111

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Bessie Harrington

2. DATE AND HOUR OF DEATH: January 3, 1967 | 1:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 901 Saratoga Street Baltimore, Maryland 21223

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 18-01

D. STREET ADDRESS (If rural, give location): 901 Saratoga Street

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Aug. 22, 1881

9. AGE (In years last birthday): 85

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Means

14. MOTHER'S MAIDEN NAME: Katie Lee

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Jane Brown ADDRESS: 901 Saratoga Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Acc. — 6 days.

DUE TO

(B) Hypertensive Cardio Vas. Dis. — years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 1965 19 to Jan 2 1967 that (I) (we) last saw the deceased alive on 1/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles Commasello Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan. 4/67

23C. PHYSICIAN'S NAME (Type): Charles Commasello M.D.

23D. ADDRESS: 910 W. Lombard St Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-7-67

24C. NAME of CEMETERY or CREMATORY: Mt. Zion Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 6 1967

25B. NAME OF REGISTRAR: Robert E. Tarkyna

25C. FUNERAL DIRECTOR: Arlington S. Phillips ADDRESS: 1727 N. Monroe Street

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
S-150

67 0112

BALTIMORE CITY HEALTH DEPARTMENT

67 0112

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM C. SPOHN

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 | 6:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 837 E. 30th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New Jersey
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Side V227
D. STREET ADDRESS (If rural, give location): 24 Whippoorwill Way

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Aug. 6, 1918
9. AGE (In years last birthday): 48
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director - Hospital Supplies
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ? Spohn
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 206-05-7642
17. INFORMANT: Mrs. Spohn
ADDRESS: same address as above

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

18. 443X

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify): Removal
23B. DATE: 1/5/1967
23C. NAME of CEMETERY or CREMATORY: Fairview Cemetery
23D. LOCATION (City, town, or county) (State): Westfield, N. J.

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Faber, M.D.
24C. FUNERAL DIRECTOR: Wm. J. Tilmon & Sons
ADDRESS: Balto., Md. North & Pa.

VS 151-REV. 1/1/65

M-240

BIRTH NO. 67 0113

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0113

1. NAME OF DECEASED (Type or Print): McGill, James T. Jr.

2. DATE AND HOUR OF DEATH: 1/3/67 10.05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI Hosp. of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: ~~BALTO~~ MD. B. COUNTY: USA. Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 33-00

D. STREET ADDRESS (If rural, give location): 1611 Lyle Ct. # 34

5. SEX: MALE

6. RACE: W.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7/16/41

9. AGE (In years last birthday): 25

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James T. McGill, Sr.

14. MOTHER'S MAIDEN NAME: Elizabeth Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): yes (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: 220 38 6652

17. INFORMANT: Mrs. Ruth E. McGill ADDRESS: 1611 Lyle Court 21234

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 204.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myeloid leukemia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 30 1966 to JAN 3 1967, that (I) (we) last saw the deceased alive on JAN 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: P. Pacharn M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/3/67

23C. PHYSICIAN'S NAME (Type): PRAPHOT PACHARN. M.D.

23D. ADDRESS: SINAI HOSP. OF BALTIMORE. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/'67

24C. NAME of CEMETERY or CREMATORY: Lake View Memorial Park

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-30d

BIRTH NO. 67 0114

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0114

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BOYD, MARGARET MARY

2. DATE AND HOUR OF DEATH: 1-5-67 11:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 NORTH CHARLES GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: Baltimore Co., Balto Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Loch Raven Village 53-00
D. STREET ADDRESS (If rural, give location): 8138 LOCH RAVEN BLVD.

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7-28-02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier - Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: EDWARD LARKIN
14. MOTHER'S MAIDEN NAME: MARY GORRICK
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: NORTH CHARLES GENERAL HOSPITAL CHART — ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 330X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE CEREBRAL HAEMORRHAGE

DUE TO

(B) RUPTURE BERRY ANEURYSM

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-5-1967 to 1-5-1967, that (I) (we) last saw the deceased alive on 1-5-67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chanthana Sudhimondala M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-5-67
23C. PHYSICIAN'S NAME (Type): Dr. ALLIEGRO Anselmo Allegro M.D.
23D. ADDRESS: 8155 LOCH RAVEN BLVD. BALTO. Md 21212

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fallon
25C. FUNERAL DIRECTOR: Wm. J. Tilmer & Sons — ADDRESS: Balto, Md.

VS 150-REV. 1/1/65

M-524

BIRTH NO. 67 0115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0115

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Ann Mengel

2. DATE AND HOUR OF DEATH: January 2, 1967 | M.

CERTIFICATE AMENDED 1-16-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-01
D. STREET ADDRESS (If rural, give location): 518 Rose Hill Terrace

5. SEX: ~~Male~~ Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 4/18/1889
9. AGE (In years last birthday): 77
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thompson
14. MOTHER'S MAIDEN NAME: Susan Linigen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. John Mengel ADDRESS: 645 Piccadilly Rd.

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis — 6 hours
DUE TO
(B) Arteriosclerosis — 15 yrs
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1958, 19 to 1-2, 19 67, that (I) (we) last saw the deceased alive on 1-2, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Franklin E. Leslie M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-4-67
23C. PHYSICIAN'S NAME (Type): Franklin E. Leslie M.D.
23D. ADDRESS: 302 E 33rd Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/'67
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Baltimore St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-560

67 0116

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0116

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT C. MUNROE

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 | 6:15 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 316 Whitridge Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03

D. STREET ADDRESS (If rural, give location): 316 Whitridge Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married	10/19/1908	58				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Freight Conductor	PRR	Baltimore, Maryland	USA

13. FATHER'S NAME: Thomas Munroe

14. MOTHER'S MAIDEN NAME: Sara Councilman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-07-9636

17. INFORMANT: Mrs. Marian R. Munroe ADDRESS: 316 Whitridge Ave.

MEDICAL CERTIFICATION

1B. 443 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive and Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/9/'67

23C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Faherty

24C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Baltimore St.

VS 151-REV. 1/1/65

S-360 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0117 Registered No. 67 0117

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (CHARLES PALERMON STARR) STARR, CHARLES

2. DATE AND HOUR OF DEATH 4 JAN. 67 6:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 Univ. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD. B. COUNTY BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 21206 26-01

D. STREET ADDRESS (If rural, give location) 5619 MAYVIEW AVE

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	6-15-10	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Counter Man - Seafood	Retired	BALTO Md.	USA

13. FATHER'S NAME CHARLES M. STARR

14. MOTHER'S MAIDEN NAME BLANCHE WHITAKER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-10-0572

17. INFORMANT Mrs. Marguerete B. Starr (wife) ADDRESS 5619 Mayview Ave. 21206

MEDICAL CERTIFICATION

1B. 393X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL VASC. ACC. — 1 WK

DUE TO

(B) RENAL FAILURE - PROGRESSIVE — 2-3 WKS

DUE TO

(C) G-I HEMMHORRAGE — 6 HRS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 12-26 1966 to 1-4 1966, that (I) (we) last saw the deceased alive on 1-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.

23A. SIGNATURE Philip M. Ashman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 1-4-67

23C. PHYSICIAN'S NAME (Type) PHILIP M. ASHMAN M.D.

23D. ADDRESS University Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 6. 1967	Maplewwod Cemetery	Elkins, West Virginia

25A. DATE REC'D BY REGISTRAR OF DEATHS JAN 9 1967

25B. NAME OF REGISTRAR Robert E. Fallon

25C. FUNERAL DIRECTOR HENRY SANDER & SONS. INC. ADDRESS Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-622 1

BIRTH NO. 67 0118 69 35 7 MARKIEWICZ, GEORGE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0118

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GEORGE MARKIEWICZ

2. DATE AND HOUR OF DEATH: 1/4/67 | 2:15 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1-03
D. STREET ADDRESS (If rural, give location): 638 SOUTH LAKEWOOD AVENUE

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 3/12/98
9. AGE (In years last birthday): 68
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed
10B. KIND OF BUSINESS OR INDUSTRY: Lakewood Reupholstery Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE MARKIEWICZ
14. MOTHER'S MAIDEN NAME: CATHERINE BASINSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-07-0957
17. INFORMANT: Wife, Mrs. Catherine Markiewicz, #4,a,b,c,d
ADDRESS

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 356 X

(A) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 30 mins

DUE TO

(B) Pulmonary Artery Embolis — 30 Mins

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 29 December, 1966
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Retinal Detachment
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12/27 1966 to 1/4/ 1967, that (I) (we) last saw the deceased alive on 1/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Peter Morse M.D.
M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): PETER H. MORSE M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-1967
24C. NAME of CEMETERY or CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): German Hill Rd. Dundalk, Md. 21222

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Tarlyan
25C. FUNERAL DIRECTOR, ADDRESS: John J. Duda, Baltimore, Md. 21224

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

K-266

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0119 66-23611 Registered No. 67 0119

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM KUCHERER

2. DATE AND HOUR PRONOUNCED DEAD: January 2, 1967 | 8:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 40 St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: //////// Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #27 53-00

D. STREET ADDRESS (If rural, give location): 4027 Twin Circle Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Never Married	Nov. 1, 1966		2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	none	Baltimore, Maryland	USA

13. FATHER'S NAME: William M. Kucherer

14. MOTHER'S MAIDEN NAME: Elizabeth Dodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	None	None	Mr. William M. Kucherer (father)	Same as #4

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial Pneumonitis (SDII)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/2/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	Jan. 4, 1967	Glen Haven Mem. Park	Glen Burnie, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Fowler	R. V. Singleton	Glen Burnie, Md.

VS 151-REV. 1/1/65

D-140 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0120

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0120

1. NAME OF DECEASED (Type or Print): Walton Duvall

2. DATE AND HOUR OF DEATH: 1/3/67 4:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 808 St. Paul St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: 7/28/00
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer, ret.
10B. KIND OF BUSINESS OR INDUSTRY: US Gov't
11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md. ~~XXXXXXXXXXXXXXXX~~
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Reinhold Duvall
14. MOTHER'S MAIDEN NAME: Mary Willard

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): no Unknown
16. SOCIAL SECURITY NO.: 213-16-5576
17. INFORMANT: Mrs. Saunders Duvall, Sister-in-law — ADDRESS: 8 Steele St. Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C) Meningitis, probably bacterial — 2 days

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

340.3

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Dehydration

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/2 1967 to 1/3 1967, that (I) (we) last saw the deceased alive on Jan. 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Louis E. Grenzer M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/67
24C. NAME of CEMETERY or CREMATORY: Salem Cemetery
24D. LOCATION (City, town, or county) (State): Annapolis, A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Beverley E. Hopping — ADDRESS: Beverley E. Hopping
Hopping Funeral Home — Annapolis, Md.

VS 150-REV. 1/1/65

34-40-81 $1 $50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0121 Registered No. 67 0121

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MILTON G. SHANNON, SR.

2. DATE AND HOUR OF DEATH: Jan. 3, 1967 4.15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 21224, 4940 Eastern Ave. Baltimore, Maryland

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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-12

D. STREET ADDRESS (If rural, give location): 4940 Eastern Avenue 21224

5. SEX: Male 6. RACE: White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married 8. DATE OF BIRTH: 4-29-15 9. AGE (In years at last birthday): 51 If Under 1 Yr. Months Days Hours If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treatment worker 10B. KIND OF BUSINESS OR INDUSTRY: Sanitation Dept 11. BIRTHPLACE (State or foreign country): Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Milton P. Shannon 14. MOTHER'S MAIDEN NAME: Elizabeth Jebhardt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) ~~unknown~~ (If yes, give war or dates of service): no 16. SOCIAL SECURITY NO. 17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue 21224 ADDRESS

MEDICAL CERTIFICATION

18. 002.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulm. Tuberculosis — 8 yrs

DUE TO

(B) Chron. Obstr. Bronchopul. Disease — 4 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED: While At Work ☐ ~~Not While At Work~~ ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 7-19 1962 to 1-3 1967 that (I) (we) last saw the deceased alive on 1-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Herman Schaerf M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 1-3-67

23C. PHYSICIAN'S NAME (Type): HERMAN SCHAERF M.D. 23D. ADDRESS: 4940 Eastern Avenue BALTO. CITY HOSPITALS Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1-6-1967 24C. NAME of CEMETERY or CREMATORY: Gradens of Faith 24D. LOCATION (City, town, or county) (State): Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967 25B. NAME OF REGISTRAR: Robert E. Falkenhan 25C. FUNERAL DIRECTOR ADDRESS: JOHN J. DUDA, Dundalk, Maryland 21222

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
T-512

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH No. 67 0122 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 67 0122

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Robert Thompson Jr.

2. DATE AND HOUR PRONOUNCED DEAD: 1/3/67 8:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 200 E. Lafayette Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 200 E. Lafayette Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
male	white	Divorced	Jan. 21- 1916	50		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe insulator	Construction	Kentucky	U.S.A.

13. FATHER'S NAME: Robert L. Thompson Sr.

14. MOTHER'S MAIDEN NAME: Elsie Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes, (If yes, give war or dates of service) WWII, 1943

16. SOCIAL SECURITY NO. 213-21-3594

17. INFORMANT: Sister, Mrs. Mary E. Kasper, ADDRESS 7417 School Ave. Dundalk, Md. 21222

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 + 1 002.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Pulmonary tuberculosis

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Jan-6-1967
23C. NAME of CEMETERY or CREMATORY: Baltimore National
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Fashyna
24C. FUNERAL DIRECTOR: JOHN J. DUDA, ADDRESS Dundalk, Maryland 21222

VS 151-REV. 1/1/65

S-252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0123 Registered No. 67 0123

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ludwik (Louis) Szczesniakowski

2. DATE AND HOUR OF DEATH: January 1, 1967 4:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 222 S. Colington Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1-05
D. STREET ADDRESS (If rural, give location): 222 S. Colington Ave

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8/10/98
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired,
10B. KIND OF BUSINESS OR INDUSTRY: Shoe Factory
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Andrew Szczesniakowski
14. MOTHER'S MAIDEN NAME: Catherine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-30-5001
17. INFORMANT: (Wife) Mrs. Michalina Szczesniakowski ADDRESS: 222 S. Colington Ave. Balto. Md. 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr. on 1/1/67 4:00 p.m.
DUE TO
(B) Emphysema — 1963-1967
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: None

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 1963 to 1/1/67 19..., that (I) (~~we~~) last saw the deceased alive on 12/24 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: B. Martin Middleton M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): Martin B. Middleton M.D.
23D. ADDRESS: 3350 Wilkens Ave. Baltimore, Maryland 21229

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/67
24C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: John J. Duda Inc. ADDRESS: 2829 Hudson St. Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0124 Registered No. 67 0124

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LULA ALLEN

2. DATE AND HOUR OF DEATH: 1/1/67 1:20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Baltimore Balt. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE DUNDALK 53-00

D. STREET ADDRESS (If rural, give location): 7425 ST. PATRICIA CT. 21222

5. SEX: FEMALE

6. RACE: WHITE

7. ~~MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)~~: Widowed

8. DATE OF BIRTH: 7-13-1900

9. AGE (In years last birthday): 66

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RUFUS WEAVER, William

14. MOTHER'S MAIDEN NAME: REBECCA SMITH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-05-1540

17. INFORMANT: Daughter, Betty Betz, ADDRESS: 1907 Dineen Ave. Dundalk, Md. 21222

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PUL. EMBOLISM (INFARCT) U/S MYO: INFARCT — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

DUE TO

(B) NEPHROTIC SYNDROME

DUE TO

(C) AZOTEMIA

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: NEPHROTIC SYNDROME — MONTHS

19A. DATE OF OPERATION: 6

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/23 1966 to 1/1 1967, that (I) ~~(we)~~ last saw the deceased alive on 1/1 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Francisco Baltazar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/1/67

23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR M.D.

23D. ADDRESS: CHURCH HOME AND HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/4/67

24C. NAME of CEMETERY or CREMATORY: Forest Cemetery

24D. LOCATION (City, town, or county) (State): Upperco, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Jackson

25C. FUNERAL DIRECTOR: John J. Duda, ADDRESS: 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

32-44-90 FR A1 S 36

BIRTH NO. 67 0125

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0125

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): NINA ANDERSON

2. DATE AND HOUR OF DEATH: 1/1/67 7 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland 21224
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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Balt. Co
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Dundalk RURAL 53-00
D. STREET ADDRESS (If rural, give location): 214 Pinewood Road 21222

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1-11-30
9. AGE (In years last birthday): 36
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Pat A. Heflin
14. MOTHER'S MAIDEN NAME: Trixie Heflin (nee Reed)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 232-44-5941
17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue
ADDRESS: 21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 154X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Squamous Cell Ca of Rectum — 2 Years
DUE TO c Metastasis

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 27 1966 to 1/1 1967, that (I) (we) last saw the deceased alive on 1/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sidney D. Kreider M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/1/67
23C. PHYSICIAN'S NAME (Type): Sidney D. Kreider M.D.
23D. ADDRESS: 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/67
24C. NAME of CEMETERY or CREMATORY: Mt. Carmel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fairbairn
25C. FUNERAL DIRECTOR: John J. Duda
ADDRESS: 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

1
B-653

67 0126
BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0126

1. NAME OF DECEASED (Type or Print): Thomas F. Brand

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 5:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED 1-16-67

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-42
D. STREET ADDRESS (If rural, give location): 2534 ~~Southdene Ave.~~ SOUTHDENE AVE.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: AUG. 10, 34
9. AGE (In years last birthday): 32
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FIREMAN
10B. KIND OF BUSINESS OR INDUSTRY: CITY
11. BIRTHPLACE (State or foreign country): N. J.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: FRANKLIN W.
14. MOTHER'S MAIDEN NAME: MARY EMBLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): YES (If yes, give war or dates of service): KOREAN WAR
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: FRANK ~~BRAND 2536 SOUTHDENE RD~~ Frank W. Brand
ADDRESS: 2536 Southdene Ave.

MEDICAL CERTIFICATION

18. E 8161 SS#213-309191

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemothorax
DUE TO
(B) Transection of aorta
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 17-02 Lafayette Ave. and Druid Hill Ave.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 2 ~~66~~ 1967 5:00p.m.
21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Thrown from fire truck which was struck by car.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 1/6/67
23C. NAME of CEMETERY or CREMATORY: BALTO. NAT.
23D. LOCATION (City, town, or county) (State): BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Fabian
24C. FUNERAL DIRECTOR: Paul E. Chenault
ADDRESS: 3617 Chestnut Ave.

VS 151-REV. 1/1/65

N 862.2

Letter from M.E.'s office & V.S. 153
1-16-67 M.H.

H-413

BIRTH NO. 67 0127

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0127

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Stella E. Hilliard

2. DATE AND HOUR OF DEATH: 1/5/1967 5:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Gardens Convalescent Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4943 Belair Rd.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 9/26/1882
9. AGE (In years last birthday): 84
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Evans
14. MOTHER'S MAIDEN NAME: Etta Carlton

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dr. Evans Hilliard — ADDRESS: 510 Woodside Rd #29

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 490 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, bilateral — 4 days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral vascular thrombosis

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 1 1967 to JAN 5 1967, that (I) (we) last saw the deceased alive on JAN 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sebastian Russo M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/6/67
23C. PHYSICIAN'S NAME (Type): Dr. Sebastian Russo M.D.
23D. ADDRESS: 5017 Harford Rd. Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-67
24C. NAME of CEMETERY or CREMATORY: Hermitage Baptist Church Cem.
24D. LOCATION (City, town, or county) (State): Churchview, Va.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. ADDRESS: Balto., Md.

VS 150-REV. 1/1/65

A-146

BIRTH NO. 67 0128

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0128

1. NAME OF DECEASED (Type or Print): Theresa Hiebler

2. DATE AND HOUR OF DEATH: Jan. 5, 1967 | 6:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 7441 Durwood Rd

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 4/13/26

9. AGE (In years last birthday): 40

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Hecht. Co.

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jesse ~~Morton~~ BURTON

14. MOTHER'S MAIDEN NAME: NELDA BROUILLETTE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 334-20-4185

17. INFORMANT: Francis Hiebler

ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 170X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 year.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Aug '66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Radical (R) mastectomy.

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 3 1967 to Jan 5 1967, that (I) (we) last saw the deceased alive on Jan 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/5/67

23C. PHYSICIAN'S NAME (Type): Michael Gould M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/10/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. Balto., Md.

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0129 Registered No. 67 0129

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Maude L. Maginnis

2. DATE AND HOUR OF DEATH: Jan. 5, 1967 9:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 905837 Belair Road House In the Pines Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38

D. STREET ADDRESS (If rural, give location): 1552 Wadsworth Way

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: II/2I/78

9. AGE (In years last birthday): 88

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John S. Lantz

14. MOTHER'S MAIDEN NAME: Anna Clark

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ruth Kimmerer ADDRESS: Balto. Md. 1552 Wadsworth Way

MEDICAL CERTIFICATION

18. 492X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Pneumonitis — 1 week

DUE TO

(B) Inanition — months

DUE TO

(C) Chronic Brain Syndrome — years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Large Gluteal Abscess — several months

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 6 1966 to January 5 1967, that (I) (we) last saw the deceased alive on January 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~Was called~~) (did not) view the body after death.

23A. SIGNATURE: Albert B. Bradley M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): Albert B. Bradley M.D.

23D. ADDRESS: 4900 Belair Rd. Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial ~~Removal~~

24B. DATE: I/9/67

24C. NAME of CEMETERY or CREMATORY: Oak Hill Cem.

24D. LOCATION (City, town, or county) (State): Lakeland, Florida

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-S 45

67 0130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0130

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary L. Kinlein

2. DATE AND HOUR OF DEATH: Jan. 5, 1967 | 3:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3302 Gibbons Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-44

D. STREET ADDRESS (If rural, give location): 3012 Gibbons Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	widowed	6/28/1888	78		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME: Anton Kellermann

14. MOTHER'S MAIDEN NAME: Catherine Roth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Henry Kinlein ADDRESS: 5311 Herring Run Dr.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Arteriosclerotic Cardiovascular — INTERVAL BETWEEN ONSET AND DEATH: NOV 1966

DUE TO

(B) Coronary thrombosis — 1966

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): —

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Nov 1966 to Jan 5 1967, that (I) (~~we~~) last saw the deceased alive on Jan 5, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: James E. White M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan. 6, 1967

23C. PHYSICIAN'S NAME (Type): JAMES E. White M.D.

23D. ADDRESS: 5214 Harford Rd. Baltimore 21214

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
burial	1-9-67	Holy Redeemer Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-623

BIRTH NO. 67 0131

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0131

1. NAME OF DECEASED (Type or Print): JOSEPHINE ELIZABETH BROCATO

2. DATE AND HOUR OF DEATH: January 5, 1967 [illegible] A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5914 Kavon Ave.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01

D. STREET ADDRESS (If rural, give location): 5914 Kavon Ave.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: Dec. 27, 1897 ~~xxxxxxxxxxxxxxxx~~

9. AGE (In years last birthday): 69

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dominic Serio

14. MOTHER'S MAIDEN NAME: Rose Serio

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Frances D'Ambrosia — ADDRESS: 3312 O'Donnell St.

MEDICAL CERTIFICATION

18. 416X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Embolus

DUE TO Thrombo Phlebitis Rt. Leg

(B) old Rheumatic Heart dis.

DUE TO Rt. Bundle Branch Block

(C) Atrial Fibrillation

Cardiac enlargement

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis Hypertension

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 1 1966 to Jan. 5 1967, that (I) (we) last saw the deceased alive on Jan 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter A. Anderson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan 6-67

23C. PHYSICIAN'S NAME (Type): Dr. Walter A. Anderson M.D.

23D. ADDRESS: 3001 Shannon Drive, Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 1-9-67

24C. NAME of CEMETERY or CREMATORY: Sacred Heart

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.--Baltimore, Md.-14 — ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-5 1/36

BIRTH NO. 67 0132

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0132

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) WILLIAM J. UNDERWOOD

2. DATE AND HOUR PRONOUNCED DEAD January 4, 1967 10:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Balto Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00

D. STREET ADDRESS (If rural, give location) 28 Wagner's Lane

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days / Hours / Min.
Male	White	MARRIED	OCT. 3 1905	61	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
BLACKSMITH		N.Y.	USA

13. FATHER'S NAME WAVERLY LEE UNDERWOOD

14. MOTHER'S MAIDEN NAME MAMIE WOLFERMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) UNK (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-10-0781

17. INFORMANT DOROTHY UNDERWOOD ADDRESS 28 WAGNERS L

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Petty M.D.

EXAMINER'S NAME (Type) Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/9/67	HOLLY HILL	BALTO. MD

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Fallaw	J.H. Connelly Sons	300 Mora

VS 151-REV. 1/1/65

G-567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0133 Registered No. 67 0133

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SIGMUND GMUREK

2. DATE AND HOUR OF DEATH: JAN. 3 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 MERCY HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTO Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ESSEX 53-00
D. STREET ADDRESS (If rural, give location): 541 S. MARLYN AVE

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: JULY 22, 1915
9. AGE (In years last birthday): 51
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAVERN OWNER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN GMUREK
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-10-2264
17. INFORMANT: CASIMIRA GMUREK ADDRESS: 541 S. MARLYN

MEDICAL CERTIFICATION

I

1B. 443X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Embolus
DUE TO
(B) Hypertensive Cardiovascular Disease
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Wm. A. Rodgers M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/5/67
23C. PHYSICIAN'S NAME (Type): WM. A. RODGERS M.D.
23D. ADDRESS: 815 EASTERN BLVD

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/7/67
24C. NAME of CEMETERY or CREMATORY: ST. STANISLAUS
24D. LOCATION (City, town, or county) (State): BALTO. MD

25A. DATE REC'D BY HEALTH DEPT. JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: JOS. CONNELLY SONS ADDRESS: 300 MACE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0134 Registered No. 67 0134

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Wilson Steve

2. DATE AND HOUR OF DEATH: 1-3-67 9:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Harford Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cardiff 62.00
D. STREET ADDRESS (If rural, give location): Main Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 11/30/05
9. AGE (In years last birthday): 61
If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter & Polisher
10B. KIND OF BUSINESS OR INDUSTRY: Green Marble
11. BIRTHPLACE (State or foreign country): Cardiff, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Wilson
14. MOTHER'S MAIDEN NAME: Mary Wesley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-05-8393
17. INFORMANT: Mrs. Grace E. Jones, ADDRESS 742 E. Clarke Av York, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? bronchogenic carcinoma with obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 1/4 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1-1 1967 to 1-3 1967, that (I) (~~we~~) last saw the deceased alive on 1-3 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David S. Fedson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-3-67
23C. PHYSICIAN'S NAME (Type): David S. Fedson M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-7-67
24C. NAME of CEMETERY or CREMATORY: Slate Ridge
24D. LOCATION (City, town, or county) (State): Delta, York Co., Pa.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Tarkyna
25C. FUNERAL DIRECTOR: Harkins Funeral Home ADDRESS: Delta, Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-62/1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0135 Registered No. 67 0135

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MORSBERGER, WILLIAM THEODORE

2. DATE AND HOUR OF DEATH: 1-4-67 9:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: Anne Arundel Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): FERNDALE Glen Burnie 52-00

D. STREET ADDRESS (If rural, give location): 2 WESTDALE RD.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 10-8-86

9. AGE (In years last birthday): 80

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (RETIRED) Carpenter

10B. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM THEODORE Morsberger

14. MOTHER'S MAIDEN NAME: ALICE (unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

If yes, give war or dates of service: None

16. SOCIAL SECURITY NO.: 218 09 5020

17. INFORMANT: AND CATON AVES. ADDRESS 21229 ST AGNES HOSPITAL RECORDS, WILKENS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 401.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

(B) Fibrinous pericarditis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-1- 19 67 to 1-4- 19 67, that (I) (we) last saw the deceased alive on 1-4- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. Korbuly M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-4-67

23C. PHYSICIAN'S NAME (Type): S. KORBULY M.D.

23D. ADDRESS: CATON AND WILKENS AVE BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 7, 1967

24C. NAME of CEMETERY or CREMATORY: Glen Haven Mem Park

24D. LOCATION (City, town, or county) (State): Glen Burnie, Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fabiyma

25C. FUNERAL DIRECTOR: Richard V. Singleton

ADDRESS: Glen Burnie

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-500

BIRTH NO. 67 0136

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0136

CERTIFICATE AMENDED 1-13-67

1. NAME OF DECEASED (Type or Print): Ryan, Sister Elodie Marie, D.C.

2. DATE AND HOUR OF DEATH: January 7, 1967 | 6:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
A. NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Seton Psychiatric Institute
21

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-41
D. STREET ADDRESS (If rural, give location): Villa Saint Michael 4000 Forest Hill Road

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: 1/16/89
9. AGE (In years last birthday): 77 years
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious Nun
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boston, Massachusetts
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: ~~William Ryan~~ Martin G. Ryan
14. MOTHER'S MAIDEN NAME: ~~Elizabeth White~~ Lydia T. Fitzmaurice

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 219-54-0606 T
17. INFORMANT: Hospital records
ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary artery occlusion — 24 hours

DUE TO

(B) Coronary & general arterio-sclerosis — 5 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Manic-depressive psychosis; circular type.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 18 1963 to January 7 1967, that (I) (we) last saw the deceased alive on January 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter O. Jahrreiss M.D. Attending Phys. ☐ for Med. Director ☑ Staff Phys. ☐
23B. DATE SIGNED: January 7, 1967

23C. PHYSICIAN'S NAME (Type): Walter O. Jahrreiss, M.D.
23D. ADDRESS: 6420 Reisterstown Road, Baltimore, Md. 21215

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/9/67
24C. NAME of CEMETERY or CREMATORY: SETON
24D. LOCATION (City, town, or county) (State): on grounds Seton Inst., City.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Stewart & Bowen Co.
ADDRESS: 108 W. North Av., Ctiy

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from Seton Institute 1-13-67 M H

M-640

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0137

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0137

1. NAME OF DECEASED (Type or Print): Maurice Merrill

2. DATE AND HOUR OF DEATH: 1-7-1967 | 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore # 21225 25-04
D. STREET ADDRESS (If rural, give location): 501 Annabel Ave.

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 4-10-1890
9. AGE (In years last birthday): 76 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Howard.
14. MOTHER'S MAIDEN NAME: Lina.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family — ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBROVASCULAR HEMORRHAGE — 1 MONTH
DUE TO
(B) ACUTE MYOCARDIAL INFARCTION — 3 DAYS
DUE TO
(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — SEVERAL YEARS

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1-4 1967 to 1-7 1967, that ~~(I)~~ (we) last saw the deceased alive on 1-7 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-7-67
23C. PHYSICIAN'S NAME (Type): Harold A. Burnham M.D.
23D. ADDRESS: 1213 Light St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/10/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge
24D. LOCATION (City, town, or county) (State): Elkridge Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fairbrother
25C. FUNERAL DIRECTOR: McCully F H — ADDRESS: 237 Patapsco Ave 21225

VS 150-REV. 1/1/65

A-553

Body was released and released by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0138

BIRTH NO. 67 0138

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ARNDT ADELE M

2. DATE AND HOUR OF DEATH: Jan 4 1967 5 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6 27-01

D. STREET ADDRESS (If rural, give location): 5000 Belair Rd

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 1887

9. AGE (In years last birthday): 79

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: Ret. Grocery store

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Rudolph Habicht

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-50-4030

17. INFORMANT: Mr Melvin Arndt ADDRESS: 4009 Putty Hill Aven 36

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Calcific aortic + mitral stenosis

DUE TO

(B) ASCVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY: CHIEF OR ASST. MEDICAL EXAMINER. M.D. 1/9/67

19A. DATE OF OPERATION: 21

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from Jan 4 4:30 AM 1967 to Jan 4 5 AM 1967, that (we) last saw the deceased alive on Jan 4 4:30 AM 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE: Giselle Bretz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Jan 4 67

23C. PHYSICIAN'S NAME (Type): Giselle T. Bretz M.D.

23D. ADDRESS: UNION MEMORIAL HOSP

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-7-67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Sieberman

25C. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS: 7301 Belair Road 36

VS 150-REV. 1/1/65

R-160

67 0139

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0139

Registered No. X

1. NAME OF DECEASED (Type or Print): LOUIS ~~LEWIS~~ D. ROBB

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 6:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: A.A.Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgewater

52-00

D. STREET ADDRESS (If rural, give location): BOX 425 ROUTE 4 HOLLY HILL HARBOR

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	NEVER MARRIED	OCTOBER 2, 1953	13				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
DEPENDENT		MARYLAND	USA

13. FATHER'S NAME: WILLARD E. ROBB

14. MOTHER'S MAIDEN NAME: VERNA IRIS MAYHEW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: WILLARD E. ROBB ADDRESS: BOX 425 ROUTE 4 EDGEWATER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E 816.4

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Craniocerebral Injury.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): St. Rt. 214, W. of Rt. 253, A.A.Co.

52-00

21D. TIME OF INJURY (APPROX.): (Month) 12 (Day) 30 (Year) '66 (Hour) A m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Passenger in auto-auto collision.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	1/9/67	CEDAR HILL CEMETERY	PRINCE GEORGES, MARYLAND

24A. DATE RECEIVED HEALTH DEPT. JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Falkenhan

24C. FUNERAL DIRECTOR: WILHELM FUNERAL HOME ADDRESS: 4308 SUITLAND ROAD, SUITLAND, MARYLAND

VS 151-REV. 1/1/65

N8 5 2 3 0 7 0 0 0 0 1 5 8

H-653

BIRTH NO. 67 0140

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0140

1. NAME OF DECEASED (Type or Print): HATTIE B. HARRINGTON

2. DATE AND HOUR OF DEATH: January 5, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Hood Nursing Home, 5213 Edmondson Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-08

D. STREET ADDRESS (If rural, give location): 239 S. Loudon Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 6-20-1880

9. AGE (In years last birthday): 86

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Wesley Tracey

14. MOTHER'S MAIDEN NAME: Sarah Bareham

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Margaret W. Harrington, 239 S. Loudon Ave. ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X

CAUSE OF DEATH

(A) Arteriosclerotic Hypertensive C.V. Disease

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1961 19 to 1/5 19 67, that (I) (we) last saw the deceased alive on 1/5/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Edward S. Kallins M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): Dr. Edward S. Kallins M.D.

23D. ADDRESS: 4300 Liberty Heights Avenue, Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

F-260

67 0141

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0141

1. NAME OF DECEASED (Type or Print): BENJAMIN FISHER

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 | 5:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 35 Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-02

D. STREET ADDRESS (If rural, give location): 135 N. Glover Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	2/3/97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer-Steam	Edgewood Arsenal	Maryland	U.S.A.

13. FATHER'S NAME: Joseph Sledz

14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	WW I	216-12-3846	Mrs.Florence Skierski,	627 S.Linwood Av

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E900.0

(A) Lobar Pneumonia

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Multiple Rib Fractures.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 135 N. Glover Street 6-02

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 1 (Year) '67 (Hour) A m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fall down stairs.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City or county) (State)
Burial	1/9/67	Holy Rosary	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	R. E. Fisher M.D.	M.F.SADOWSKI & SONS,	1808 EASTERN AVE

VS 151-REV. 1/1/65

N807.2 0140

B-210

BIRTH NO. 67 0142 64-28628

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0142

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BRUCE BISHOP

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 | 8:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-02

D. STREET ADDRESS (If rural, give location): 1427 Washington Boulevard

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Male	White	Single	Unknown 1964		26

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child	None	Baltimore Md.	U.S.A.

13. FATHER'S NAME: Charles Bishop Jr.

14. MOTHER'S MAIDEN NAME: Viola Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Agatha Bishop ADDRESS: 5102 Cordelia Ave B, Md.

MEDICAL CERTIFICATION

18. E885.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lead poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1417 Washington Boulevard 21-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 10-66 to 1-67 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Ate paint on woodwork

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1966

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/9/67	Mt. Olivet Cem.	2930 Melrose Ave

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Fahrney	John J. Cowanston Inc.	951 Hollins St. 23, Md.

VS 151-REV. 1/1/65

N 966.0

M-66 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0143 Registered No. 67 0143

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BERTHA MOORE

2. DATE AND HOUR OF DEATH: JAN 6, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 HOOD CONV. HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: BALTO Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE 53-00
D. STREET ADDRESS (If rural, give location): 113 FAIRFIELD DRIVE

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 12/23/77
9. AGE (In years last birthday): 89
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Godfried Rice
14. MOTHER'S MAIDEN NAME: Augusta K. Bach

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HELEN SMITH ADDRESS: 5721 Edmondson Ave -28

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.C.V.D — 3 years

DUE TO

(B)

DUE TO

(C) Congestive Failure — 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hiatus Hernia

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: White At Work ☐ Not White At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-10 1961 to 1-6-67 19, that (I) (we) last saw the deceased alive on 1-6-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James H Stowell M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-6-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Catonsville

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/9/1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn - Balto Co. - Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: E.S. MACNABB ADDRESS: 301 FREDERICK Rd 21228

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-651

67 0144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0144

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret A. Arenz

2. DATE AND HOUR OF DEATH: January 5, 1967 1:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 970 North Hill Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-01

D. STREET ADDRESS (If rural, give location): 970 North Hill Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Aug. 2, 1907

9. AGE (In years last birthday): 59

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10B. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph A. Gillespie

14. MOTHER'S MAIDEN NAME: Anna M. Bittner

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Anna B. Simms ADDRESS: 3202 Chesterfield Ave.

MEDICAL CERTIFICATION

18. I 170 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Adenocarc left Breast

DUE TO

(B) Local & gent metastasis

DUE TO

(C) arteriosclerotic Heart Disease

ch Congestive failure

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): —

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING ~~CAUSES OF DEATH~~?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: White At Work ☐ ~~Not~~ While At Work ☐

21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (~~this hospital~~) attended the deceased from Aug 2 1966 to Jan 5 1967, that (I) (~~we~~) last saw the deceased alive on Jan 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Donald W. Mintzer M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): Donald W. Mintzer M.D.

23D. ADDRESS: 3009 Evergreen Ave.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Faukeyma

25C. FUNERAL DIRECTOR: Ullrich Funeral Home ADDRESS: 4210 Belair Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

T-512

67 0145

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0145

1. NAME OF DECEASED (Type or Print): DANIEL J. THOMPSON

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 1:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Prince George's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hyattsville 66-00

D. STREET ADDRESS (If rural, give location): 6222 20th Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Never married	11/30/1948	18				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nursery Att.	-	Maryland	U.S.A.

13. FATHER'S NAME: Arthur L. Thompson

14. MOTHER'S MAIDEN NAME: Ann Haynes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 215-52-7286

17. INFORMANT: Mr. Arthur L. Thompson (Father)

ADDRESS: (above address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E983X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-cerebral Injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Spring Grove State Hospital

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 3 '67 P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Received injuries during altercation.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [X]

ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/7/67	Mt. Olivet Cemetery	Washington, D.C.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Fahrney	Nalley's Funeral Home Inc.	Mt. Rainier, Md.

VS 151-REV. 1/1/65

N869.2

R-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0146 Registered No. 67 0146

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William Harry Rollins

2. DATE AND HOUR OF DEATH: Jan. 5, 1967 | 3: 50 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-01

D. STREET ADDRESS (If rural, give location): 1916 Gough Street #31

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7/17/98

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Deckhand

10B. KIND OF BUSINESS OR INDUSTRY: Seafarer

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Rozonjowski

14. MOTHER'S MAIDEN NAME: Agnes Novak

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): USA 1916-1920?

16. SOCIAL SECURITY NO.: 186-18-6566

17. INFORMANT: Records- US PHS Hospital, Balto, Md. Catherine Rollins, wife, above (nee Smith)

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure, — Days

DUE TO clinical, with acute pericarditis

(B) Arteriosclerotic heart disease — Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic bronchitis — Years

Emphysema — Years

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 4 19 67, to Jan. 5 19 67, that (I)/(we) last saw the deceased alive on Jan. 5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/5/67

23C. PHYSICIAN'S NAME (Type): John N. Petrucci, Sr. Surgeon M.D.

23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/7/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fairgrave

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 2801-03-05 E. Madison Street #5

VS 150-REV. 1/1/65

RGB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0147 Registered No. 67 0147

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Loretta Ruppert

2. DATE AND HOUR OF DEATH: 1-5-1967 | 7 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 4312 Glenarm Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 26-01
D. STREET ADDRESS (If rural, give location): 4312 Glenarm Avenue #6

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3-22-1895
9. AGE (In years last birthday): 71
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fredrick W. Leonard
14. MOTHER'S MAIDEN NAME: Amelia Geller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-30-1386
17. INFORMANT: Mrs June Payne ADDRESS: 4312 Glenarm Avenue

MEDICAL CERTIFICATION

1B. 180X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral metastases — 2 month
DUE TO
(B) of renal cell cancer — 1 yr
DUE TO
(C) Rt kidney

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 18 1966 to Jan 6 1967, that (I) (we) last saw the deceased alive on Jan 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. Rigler M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): RICHARD R. RIGLER M.D.
23D. ADDRESS: 1 W. OVERLEA AVE. BALTO., MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-1967
24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farkuma
25C. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 7401 Belair Road (36)

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1 W-432

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0148 Registered No. 67 0148

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARSHA DIETZ WILDSTEIN

2. DATE AND HOUR PRONOUNCED DEAD: January 1, 1967 10:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 3911 Liberty Heights Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3911 Liberty Heights Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: November 23, 1944
9. AGE (In years last birthday): 22
If Under 1 Yr. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hyman Dietz
14. MOTHER'S MAIDEN NAME: Clara Cohen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mr. Charles Wildstein
ADDRESS: 4304 Miami Place #7

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E970.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Overdose of Barbiturates

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3911 Liberty Heights Avenue
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): December '66 ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Unknown

22. I certify that I held an Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [X]

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/2/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/4/67
23C. NAME of CEMETERY or CREMATORY: Hebrew Young Men
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.
ADDRESS: 6010 Reist., Rd.

VS 151-REV. 1/1/65

N 971.0

C 1355

BIRTH NO. 67 0149

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0149

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Samuel Goodman

2. DATE AND HOUR OF DEATH: January 2, 1967 — 10:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 421 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): Temple Garden Apartments, Apt. 905

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 87 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manufacture
10B. KIND OF BUSINESS OR INDUSTRY: Women's Clothing
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Bertha ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-03-4540
17. INFORMANT: Mrs. Miriam Goodman — ADDRESS: Temple Garden Apartments

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — 12 hours

DUE TO

(B) Generalized arteriosclerosis — 10 years

DUE TO

(C) — —

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — —

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Jan 19 63 to Jan 2 19 67, that (I) (we) last saw the deceased alive on Jan 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert I. Levy — M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/3/67
23C. PHYSICIAN'S NAME (Type): Dr. Robert I. Levy M.D.
23D. ADDRESS: Medical Arts Building

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/67
24C. NAME of CEMETERY or CREMATORY: Baltimore Hebrew
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc. — ADDRESS: 6010 Reisterstown

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0150 — Registered No. 67 0150

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Philip Jacobs

2. DATE AND HOUR OF DEATH: January 4, 1967 — 3 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 4008 Glengyle Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Married		76				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant	Retail	Russia	USA

13. FATHER'S NAME: Max Jacobs

14. MOTHER'S MAIDEN NAME: Esther ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-32-7379

17. INFORMANT: Mrs. Mollie Jacobs, ADDRESS: 4008 Glengyle Avenue

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Coronary occlusion	15 min
(B) DUE TO	art Sel cv disease	10 yr
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinsonism

19A. DATE OF OPERATION: 0 non — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/2 1966 to 1/4 1967, that (I) (we) last saw the deceased alive on 1/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Maurice Feldman M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): MAURICE FELDMAN JR. M.D.

23D. ADDRESS: LATROBE BLDG

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/67

24C. NAME of CEMETERY or CREMATORY: Beth Isaac Adath Israel

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Solomon Bloc Inc

ADDRESS: 6010 Reist Road

VS 150-REV. 1/1/65

K-145 67 0151

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0151

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Bertha Kaplan

2. DATE AND HOUR OF DEATH: January 4, 1967 | 2 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: —

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-18

D. STREET ADDRESS (If rural, give location): 4855 REISTERSTOWN ROAD

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed.

8. DATE OF BIRTH: 12-18-89

9. AGE (In years last birthday): 77

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-52-2412

17. INFORMANT: Mr. Nathan Caplan, 3411 Glen Avenue

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3/67 19 to 1/4/67 19, that (I) (we) last saw the deceased alive on JANUARY 4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn B. Lewis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: JANUARY 4, 1967

23C. PHYSICIAN'S NAME (Type): MELVYN B LEWIS M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE, INC

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/5/67

24C. NAME of CEMETERY or CREMATORY: Tifereth Israel Anshe Sfard

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reisterstown

VS 150-REV. 1/1/65

W-5 60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0152 Registered No. 67 0152

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH WEINER

2. DATE AND HOUR OF DEATH: 1/2/67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP. OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 2503 FARRINGDON RD.

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED 8. DATE OF BIRTH: August 4, 1910 9. AGE (In years last birthday): 56 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wholesale 10B. KIND OF BUSINESS OR INDUSTRY: Drugs 11. BIRTHPLACE (State or foreign country): Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Morris Weiner 14. MOTHER'S MAIDEN NAME: Dora ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W. W. 11 16. SOCIAL SECURITY NO.: Unknown 17. INFORMANT: Mrs. Sylvia Weiner ADDRESS: 2503 Farringdon Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/2/ 1967 to 1/2/ 1967, that (I) (we) last saw the deceased alive on 1/2/ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 1/2/67

23C. PHYSICIAN'S NAME (Type): MILTON B. KIRSH, M.D. M.D. 23D. ADDRESS: 4000 Northern Parkway

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1/4/67 24C. NAME of CEMETERY or CREMATORY: Shaarei Tfiloh 24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967 25B. NAME OF REGISTRAR: Robert E. Tarkington 25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc. ADDRESS: 6010 Reist. Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-261

67 0153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0153

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anthony Richardson

2. DATE AND HOUR OF DEATH: 1-6-67. 3 ~~10 AM~~ | 3 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University of Maryland Hosp Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: USA Howard Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Jessup 63-00

D. STREET ADDRESS (If rural, give location): Rt 2

5. SEX: M

6. RACE: N N

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3-11-00

9. AGE (In years last birthday): 66

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman (Ret.)

10B. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Manning, S.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Johnny Richardson

14. MOTHER'S MAIDEN NAME: Rosie Mongore

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-01-1642

17. INFORMANT: Dorothy Richardson, Rt 2 ADDRESS: Jessup, Md

MEDICAL CERTIFICATION

18. 578 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Renal Failure

DUE TO

(B) Post Op Hypotension

DUE TO

(C) Peritonitis 2° Bowel Perf.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Perforated Small Bowel

19A. DATE OF OPERATION: 12/27 & 12/30

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Peritonitis

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 26 Dec 1966 to 6 Jan 1967, that (I) (we) last saw the deceased alive on 5 Jan 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Michael B Flynn M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 6 Jan 67

23C. PHYSICIAN'S NAME (Type): MICHAEL B FLYNN M.D.

23D. ADDRESS: Univ Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Carver Memorial Pk.

24D. LOCATION (City, town, or county) (State): Laurel Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Tarbayne

25C. FUNERAL DIRECTOR: Burnell B. Oden

ADDRESS: Balto. Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-500

BIRTH NO. 67 0154

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0154

1. NAME OF DECEASED (Type or Print): LAWRENCE E. MOON

2. DATE AND HOUR OF DEATH: 1-6-67 11:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-05

D. STREET ADDRESS (If rural, give location): 1301 Moreland Ave

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 4-5-88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian

10B. KIND OF BUSINESS OR INDUSTRY: Cemetery

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: MOON

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): ONE

16. SOCIAL SECURITY NO.: 220-01-1319

17. INFORMANT: Joseph J. Kasser

ADDRESS: 3711 Echodale Ave

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Metastasis malignant melanoma of right eye — 19 0.7

DUE TO

(B) Congestive heart failure

DUE TO

(C) Uremia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-18-66 19 to 1-6 19 66, that (I) (we) last saw the deceased alive on 1-6 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lucas C. Widhyaphum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): LUCAS C. WIDHYAPHUM M.D.

23D. ADDRESS: Lutheran Hospital of Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Baltimore National Cem

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE RECEIVED BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Larkin

25C. FUNERAL DIRECTOR: Thomas J. Kenny Inc

ADDRESS: 1600 Hollins St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-500

67 0155

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0155

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT MAHONEY

2. DATE AND HOUR PRONOUNCED DEAD: January 7, 1967 11:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 755 W. Lexington Street Apt. 302

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 1554 W. Fayette Street

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married-Sep.
8. DATE OF BIRTH: 8-8-13
9. AGE (In years last birthday): 53
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anna Wright
ADDRESS: 130 Sharpnick-Phila., Pa.

MEDICAL CERTIFICATION

18. E982X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of Back
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Unknown
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Unknown

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 7 (Year) '67 (Hour) ? P.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Was stabbed

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-13-67
23C. NAME of CEMETERY or CREMATORY: Church Cemetery
23D. LOCATION (City, town, or county) (State): Oldham, Virginia

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Fabiano
24C. FUNERAL DIRECTOR: George Kelson
ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

N 874.2

W-45

BIRTH NO. 66 26731 0156

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0156

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HAWKORY L. Williams

2. DATE AND HOUR OF DEATH: 1/7/67 11 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Baltimore~~ B. COUNTY: MARYLAND
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-03
D. STREET ADDRESS (If rural, give location): 2413 McCulloh St.

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: 12/12/66
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: 26 Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Lewis W. Williams Jr.
14. MOTHER'S MAIDEN NAME: Peggy ANN
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: FROM RECORDS Lloyd J. Kramer MD. ADDRESS: SINAI Hosp.

MEDICAL CERTIFICATION

1B. 7544 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Congenital Heart Decease
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lloyd J. Kramer M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓
23B. DATE SIGNED: 1/7/67
23C. PHYSICIAN'S NAME (Type): LLOYD I. KRAMER M.D.
23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-67
24C. NAME of CEMETERY or CREMATORY: Church Cemetery
24D. LOCATION (City, town, or county) (State): Accomah County, Virginia

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

1
T-612

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0157 Registered No. 67 0157

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT N. TRIPPS

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1820 Mosher Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 1820 Mosher Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Mar. 26, 1913
9. AGE (In years last birthday): 53 yr.
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Tripp
14. MOTHER'S MAIDEN NAME: Francis Clay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212035701
17. INFORMANT: Edna Tripp ADDRESS: 1820 Mosher Street

MEDICAL CERTIFICATION

18. 443X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic lung disease

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-9-67
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Pk.
23D. LOCATION (City, town, or county) (State): Arbutus Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Fahrney
24C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

1

J-250

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0158 Registered No. 67 0158

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES JACKSON

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 10:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 566 Gold Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

14-03

D. STREET ADDRESS (If rural, give location): 566 Gold Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	single	Jan. 15, 1926	40		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Jackson

14. MOTHER'S MAIDEN NAME: Carrie Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217209934

17. INFORMANT: Carrie Stewart ADDRESS: 566 Gold Street

MEDICAL CERTIFICATION

18. 165 X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of Lung.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-10-67

23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Fakuyama

24C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

4L-200 67 0159

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0159

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Asie M. Leach

2. DATE AND HOUR OF DEATH: Jan. 6, 1967 | A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 828 Cooks Lane

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 828 Cooks Lane

28-04

5. SEX: F
6. RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3-20-1891
9. AGE (In years last birthday): 75
If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late ---- Taylor
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 235-07-9582A
17. INFORMANT: Miss Wanda Leach — ADDRESS: 828 Cooks Lane

MEDICAL CERTIFICATION

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) C.V.A. — 3 hours
DUE TO
(B) ASCVD — ?
DUE TO
(C) Hypertension, essential — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 1964 to Jan 6 1967, that (I) (we) last saw the deceased alive on Jan 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Earl Pass M.D. — Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-6-67
23C. PHYSICIAN'S NAME (Type): Earl I. Pass M.D.
23D. ADDRESS: 4001 Wilkens Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-67
24C. NAME of CEMETERY or CREMATORY: Arlington Cem.
24D. LOCATION (City, town, or county) (State): Parkersburg, W. Va.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Witzke F.D. — ADDRESS: 4101 Edmondson Av.

VS 150-REV. 1/1/65

15

B-60

BIRTH NO. 67 0160

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0160

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM F. BAHR

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 5:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 232 S. Bouldin Street

26-10

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	4-21-95	71				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Ward's Bakery	Maryland	USA

13. FATHER'S NAME: Frederick Bahr

14. MOTHER'S MAIDEN NAME: Reike Pleiss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-0126

17. INFORMANT: Mr. William L. Bahr ADDRESS: 232 S. Bouldin St. - #24

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

DATE SIGNED January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-9-67	New Cathedral Cem.	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Fahey	Witzke F.D.	4101 Edmondson Ave.

0159

VS 151-REV. 1/1/65

4 15540

BIRTH NO. 67 0161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0161

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): TINLEY, MARY G.

2. DATE AND HOUR OF DEATH: 1-6-67 | 6:30A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ZONE 29 53-00

D. STREET ADDRESS (If rural, give location): 1012 CHARING MARTIN APT C

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 2-8-10

9. AGE (In years last birthday): 56

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: EDDIE RIVENBARK

14. MOTHER'S MAIDEN NAME: MAE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-9348

17. INFORMANT: ST. AGNES HOSPITAL -CATON & WILKENS

ADDRESS: Mr. James Tinley-1012 Charring Martin Ct. 29

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

18. 4 4 3 X

(A) Intracerebral hemorrhage

DUE TO

(B) Hypertension

DUE TO

(C) Arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH:

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from JANUARY 4 1967 to JANUARY 6 1967, that (I) (we) last saw the deceased alive on JANUARY 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo E. Dibos M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-6-67

23C. PHYSICIAN'S NAME (Type): PABLO DIBOS M.D.

23D. ADDRESS: ST. AGNES HOSPITAL-CATON & WILKENS AVE

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fahey

25C. FUNERAL DIRECTOR: Witzke F.D.-4101 Edmondson Ave.

ADDRESS:

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-5-365

BIRTH NO. 67 0162

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0162

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Stromberg, Agnes

2. DATE AND HOUR OF DEATH: 1-7-67 | 4:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital 34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 1017 Francis Ave.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 2-15-90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: O'Brien, Joseph

14. MOTHER'S MAIDEN NAME: Nevin, Elizabeth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-32-4087A

17. INFORMANT: Mrs. Gerald Kerr - 1017 Francis Ave. - #27 ADDRESS: Admission Sheet

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: days

DUE TO

(B) ARTERIOSCLEROTIC HEART DISEASE — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ACUTE AND CHRONIC Cholecystitis — DAYS & YEARS

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-22 1966 to 1-7- 1967, that (I) (we) last saw the deceased alive on 1-7- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Agustin del Campo. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: JAN. 7 - 1967

23C. PHYSICIAN'S NAME (Type): AGUSTIN del CAMPO. M.D.

23D. ADDRESS: BON SECOURS HOSPITAL. BALT. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE RECEIVED BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fairley M.D.

25C. FUNERAL DIRECTOR: Witzke F.D. - 4101 Edmondson Ave. ADDRESS

VS 150-REV. 1/1/65

S-530 1

BIRTH NO. 67 0163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0163

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SMITH BEATRICE

2. DATE AND HOUR OF DEATH: 1-6-1967 1.20 A.M. P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSP. OF MARYLAND

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21207 28-02

D. STREET ADDRESS (If rural, give location): 5103 BELLEVILLE AVE.

5. SEX: FEMALE

6. RACE: COLORED

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 7-23-1896

9. AGE (In years last birthday): 70

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. SEAMSTRESS

10B. KIND OF BUSINESS OR INDUSTRY: PVT. FAMILY

11. BIRTHPLACE (State or foreign country): BALTO MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES JACKSON

14. MOTHER'S MAIDEN NAME: ROSA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: DONALD E. SMITH

ADDRESS: 3610 FOREST PK. AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 334X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arteriosclerosis

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pyelonephritis, Malnutrition.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC 9 1966 to JAN 6 1967, that (I) (we) last saw the deceased alive on JAN 6 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/9/67

24C. NAME of CEMETERY or CREMATORY: Carver Mem PK

24D. LOCATION (City, town, or county) (State): Marlboro Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fowler

25C. FUNERAL DIRECTOR: Frank Lee P. Hayes

ADDRESS: 63 & N Gilmor St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

GG 47-67-17

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0164 Registered No. 67 0164

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Luzenia Hill

2. DATE AND HOUR OF DEATH: 1/7/67 | 8:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hosp 4940 Eastern Avenue Baltimore 21224, Maryland

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: —

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 624 Roundview Rd.

5-32

5. SEX: F Female

6. RACE: N Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widow

8. DATE OF BIRTH: 10/23/92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Scotland Neck. North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Berry Dudley

14. MOTHER'S MAIDEN NAME: Annette Anthony

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS: BCH 4940 Eastern Ave. #21224

MEDICAL CERTIFICATION

I. 33 / X-1-260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Septicemia — 24 hrs

DUE TO

(B) Pneumonia — 24 hrs.

DUE TO

(C) Prolonged bed rest ≈ CVA

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes, Ess. hypertension, CHF

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 1/2 19 67 to 1/7 19 67, that (I) (we) last saw the deceased alive on 1/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Thomas Davis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): J. T. Davidson M.D.

23D. ADDRESS: BCH Baltimore, Maryland 4940 Eastern Ave. #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: Calvary

24D. LOCATION (City, town, or county) (State): Norfolk Va

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Tarkenton

25C. FUNERAL DIRECTOR: Marshall Phillips

ADDRESS: 638 N Gilmor

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

e-623 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0165 Registered No. 67 0165

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CROXTON, EVA ESTELLE

2. DATE AND HOUR OF DEATH: 1/4/67 4 00 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: 15-48

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 3602 Clifton Ave.

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 2-22-91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid

10B. KIND OF BUSINESS OR INDUSTRY: Boarding Home

11. BIRTHPLACE (State or foreign country): Lottsburg Co, VA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Croxton

14. MOTHER'S MAIDEN NAME: Catherine ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-34-6961

17. INFORMANT: MRS. BEATRICE Thompson ADDRESS: 3602 Clifton Ave

MEDICAL CERTIFICATION

1B. 4 2011

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PROBABLE MYOCARDIAL INFARCTION

DUE TO

(B) ASCVD

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC - 23 19 66 to JAN 4 19 67, that (I) (we) last saw the deceased alive on JAN 4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.

23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/7/67

24C. NAME of CEMETERY or CREMATORY: FAMILY LOT

24D. LOCATION (City, town, or county) (State): Northumberland Co, Virginia

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Parker M.D.

25C. FUNERAL DIRECTOR: HERBERT E. NUTTER ADDRESS: 3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0166 Registered No. 67 0166

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MINNIE HUBERT

2. DATE AND HOUR OF DEATH: January 5, 1967, 9.10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3001 N. Charles Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 12-02

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - 21218

D. STREET ADDRESS (If rural, give location): 3001 N. Charles Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: July 8, 1883

9. AGE (In years last birthday): 83

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hubert

14. MOTHER'S MAIDEN NAME: Louise Feller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.:

17. INFORMANT: Guy. B. Brown, Attorney ADDRESS: 450 Equitable Bldg. Baltimore 21202

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Instant

DUE TO

(B) arteriosclerotic Heart Disease — 10 yrs

DUE TO

(C) Generalized arteriosclerosis ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5-11-1955 to 1-5-1967, that (I) (we) last saw the deceased alive on 1-4-1967 and that in (my) (—) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~did not~~ view the body after death. 9:10 A.M.

23A. SIGNATURE: Robert H. Siver M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-6-67

23C. PHYSICIAN'S NAME (Type): Robert H. Siver M.D.

23D. ADDRESS: 3105 N. Charles St., Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 7, 67

24C. NAME of CEMETERY or CREMATORY: Green Mount Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: H. Sander & Sons, Inc., Balto., Md. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 016756-02-22-E1 A1

M.E. CASE NO. ~~Scott, Cath~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0167

1. NAME OF DECEASED (Type or Print): Scott. Catherine NMN

2. DATE AND HOUR OF DEATH: Jan. 4 '67 | 12 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp. Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 746 Glenwood Ave.

D. STREET ADDRESS (If rural, give location): 21-10

5. SEX: f

6. RACE: negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 04-01-07

9. AGE (In years last birthday): 59

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Smoot (D)

14. MOTHER'S MAIDEN NAME: Emma Scribel (D)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 30-136371-070

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) 3) Septic Shock

DUE TO (b) 1) Peritonitis

DUE TO (c) 2) Perinephric Abscess, Rt.

4) Renal Stone, Bilateral 4 K 15 m

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Dec. 25 '66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: acute abdomen

20A. AUTOPSY (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 25 1966 to Jan. 4 1967, that (I) (we) last saw the deceased alive on Jan 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Sun young Choi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Jan. 4 '67

23C. PHYSICIAN'S NAME (Type): SUN YOUNG CHOI, M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/9/67

24C. NAME of CEMETERY or CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Charles A Rice

ADDRESS: 661 W Barre St

VS 150-REV. 1/1/65

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B-650

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0168 Registered No. 67 0168

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JESSE BROWN

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 11:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2528 Lauretta Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-02

D. STREET ADDRESS (If rural, give location): 2528 Lauretta Avenue

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 1873 Jan.3, 1873

9. AGE (In years last birthday): 94

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UnK.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-03-4042

17. INFORMANT: Malinda Brown ADDRESS: 2528 Lauretta Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/9/67

23C. NAME of CEMETERY or CREMATORY: Mt. Calvery

23D. LOCATION (City, town, or county) (State): Brooklyn, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Lankford

24C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

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VS 151-REV. 1/1/65

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T-520

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0169 Registered No. 67 0169

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EARL THOMAS, Jr.

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 8:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): University Hospital 38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-62
D. STREET ADDRESS (If rural, give location): 117 N. Pine Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): ~~Laborer~~
8. DATE OF BIRTH: April 13, 1928
9. AGE (In years last birthday): 38
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Shipyard
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Thomas
14. MOTHER'S MAIDEN NAME: Janie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Janie Moreland ADDRESS: Seabury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E916.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) 3rd Degree Body Burns.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 117 N. Pine Street 4-02

21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 17 (Year) '66 (Hour) A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fire in bedroom of home.

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Jan. 11, 1967
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Farkas
24C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

N948.2

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BIRTH NO. 67 0170

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0170

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): PATTERSON JAMES

2. DATE AND HOUR OF DEATH: 1 3 1967 | 6.55 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hosp. of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16 05
D. STREET ADDRESS (If rural, give location): 2526 Edmondson Ave

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12-25-12
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Petersburg, Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Manfield Patterson
14. MOTHER'S MAIDEN NAME: Laura Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mande Patterson
ADDRESS: 2526 Edmondson Ave.

MEDICAL CERTIFICATION

I

1B. 271.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 min.

DUE TO

(B) Parathyroid adenoma

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12. 30. 66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Parathyroid adenoma
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12. 18 19 66 to 1. 3 19 67, that (I) (we) last saw the deceased alive on 1. 3. 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Milos Radojkovic M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1. 3. 1967

23C. PHYSICIAN'S NAME (Type): MILOS RADOJKOVIC M.D.
23D. ADDRESS: LUTHERAN HOSPITAL, BALTIMORE MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Westport (Baltimore) Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Joseph R. Rives
ADDRESS: 2222 N. Mt. Ave Baltimore, Md.

VS 150-REV. 1/1/65

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B-452

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0171 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. 67 0171

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) William John Beling

2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 2:55 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2009
D. STREET ADDRESS (If rural, give location): 1927 W. Baltimore St.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: May 15 1918
9. AGE (In years last birthday): 48
If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10B. KIND OF BUSINESS OR INDUSTRY: Eastern Produce Co
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Beling
14. MOTHER'S MAIDEN NAME: Rose Dembeck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 11
16. SOCIAL SECURITY NO.: 217 02 3378
17. INFORMANT: Rose Lavender
ADDRESS: Rt 2 Box 113 Finksburg, Md.

MEDICAL CERTIFICATION

1B. 330 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Subarachnoid hemorrhage
(A) DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Jan 11 1967
23C. NAME of CEMETERY or CREMATORY: Baltimore National Cem.
23D. LOCATION (City, town, or county) (State): Frederick Road Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: The Dippel Brothers Inc
ADDRESS: 1800 E Lombard St

VS 151-REV. 1/1/65

6-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0172 Registered No. 67 0172

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GORSKI - ANNA S

2. DATE AND HOUR OF DEATH: 1-6-67 | 4:17 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore 27-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214

D. STREET ADDRESS (If rural, give location): 5025 Crosswood Avenue

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3-31-1906

9. AGE (In years last birthday): 60

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Addelburg

14. MOTHER'S MAIDEN NAME: Jaroslawski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-01-1739

17. INFORMANT: Chas. Leo Gorski | ADDRESS: 5015 Crosswood Ave

CAUSE OF DEATH

18. 181.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	Prolonged shock, 2° to intraperitoneal hemorrhage.	72 hours
(B) DUE TO	Statu post biopsy of invasive carcinoma of urinary bladder.	7 days
(C)	Hydronephrosis, left, 2° to bladder ca.	weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral edema — 48 hrs

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: Dec 30, 1966

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bladder tumor

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no accident.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-25- 1966 to 6 January 1967, that (I) (we) last saw the deceased alive on 6 January 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: X A.H. Ghiladi M.D.

M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 6 January 1967

23C. PHYSICIAN'S NAME (Type): Abdolhamid Ghiladi M.D.

23D. ADDRESS: Bon Secours Hospital, Balt. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Holy Rosary Cemetery

24D. LOCATION (City, town, or county) (State): Balto. Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 5 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: John M Weber & Sons Inc. | ADDRESS: 401 S. Chester St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
M-460

67 0173

BALTIMORE CITY HEALTH DEPARTMENT

67 0173

BIRTH NO. 66-23952

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MICHAEL MAULER

2. DATE AND HOUR PRONOUNCED DEAD: January 8, 1967 6:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Baltimore City Hospitals

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-36

D. STREET ADDRESS (If rural, give location): 1409 Cavendish Way

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	NEVER MARRIED	11-10-1966	2 MONTHS	2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH W MAULER

14. MOTHER'S MAIDEN NAME: GEORGETTA K ABBOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: JOSEPH MAULER ADDRESS: 1409 CAVENDISH WAY

MEDICAL CERTIFICATION

18. 3-23-X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Respiratory Infection with Right Otitis Media and Interstitial Pneumonitis (SDII)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 1-10-67

23C. NAME of CEMETERY or CREMATORY: OAKLAWN CEMETERY

23D. LOCATION (City, town, or county) (State): BALTO. MARYLAND

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Falkenhan

24C. FUNERAL DIRECTOR: JOHN M WEBER + SONS INC. ADDRESS: 401 S. CHESTER ST.

VS 151-REV. 1/1/65

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0174 Registered No. 67 0174

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PIECZYNSKI MARGARET P.

2. DATE AND HOUR OF DEATH: JAN. 8, 1967 | 6 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BA
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 221 S. MADEIRA

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-13-08
9. AGE (In years): 58 — If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U. S.
13. FATHER'S NAME: GUS KANIECKI
14. MOTHER'S MAIDEN NAME: FRANCES GIELSKI
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-10-6363
17. INFORMANT: Patient. ADDRESS: 221 S. MADEIRA ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 151X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CANCER of Stomach — ?

DUE TO

(B) Pulmonary Embolism — ?

DUE TO

(C) Pyelonephritis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from 1/4/67 1967 to 1/8/ 1967, that (I) (we) last saw the deceased alive on 1/8/ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Asterlin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-8-67
23C. PHYSICIAN'S NAME (Type): DR. R. ATKINS M.D.
23D. ADDRESS: Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-12-67
24C. NAME of CEMETERY or CREMATORY: ST. STANISLAUS CEMETERY
24D. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: JOHN M WEBER & SONS INC.
ADDRESS: 401 S. CHESTER ST

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0175 Registered No. 67 0175

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEAH AMELIA LENTZ

2. DATE AND HOUR OF DEATH: JANUARY 8, 1967 | 10:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MARYLAND

4D

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: ZIP CODE 21229

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE Co. 53-00

D. STREET ADDRESS (If rural, give location): 5315 OLD FREDERICK ROAD

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-24-92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE KNELL

14. MOTHER'S MAIDEN NAME: EMMA E. SPRINGER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.

17. INFORMANT: ST. AGNES HOSPTIAL, WILKENS & CATON AVE — ADDRESS

MEDICAL CERTIFICATION

1B. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebro-vascular accident

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JANUARY 1 1967 to JANUARY 8 1967, that (I) (we) last saw the deceased alive on JANUARY 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type): ~~MANUEL~~ MIGUEL HEREDIA M.D.

23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-11-67

24C. NAME of CEMETERY or CREMATORY: LOUDON PARK CEM

24D. LOCATION (City, town, or county) (State): BALTO MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Falkenna

25C. FUNERAL DIRECTOR: WEBER FUNERAL HOME 5311 EDMONDSON AVE — ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1

R-636

BIRTH NO. 67 0176

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0176

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMILIO PARDO

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 8:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 727 S. Bond Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 727 S. Bond Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widower

8. DATE OF BIRTH: April 9, 1901

9. AGE (In years last birthday): 65

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Seaman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Spain

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 086-12-5635

17. INFORMANT: Rex Dickey Seafarers International Union

ADDRESS: 1216 E. Baltimore Street

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 15-1X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of stomach

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-10-1967

23C. NAME of CEMETERY or CREMATORY: Sacred Heart

23D. LOCATION (City, town, or county) (State): Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Falkoma

24C. FUNERAL DIRECTOR: Lilly & Zeiler Inc.

ADDRESS: 1901-07 Eastern Ave.

VS 151-REV. 1/1/65

1
W-100

BIRTH NO. 67 0177

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0177

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EULA Mae WEBB

2. DATE AND HOUR PRONOUNCED DEAD: January 7, 1967 11:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-7-8
D. STREET ADDRESS (If rural, give location): 4729 Reisterstown Road

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: June 18 1947
9. AGE (In years last birthday): 19
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assembly Line Operator
10B. KIND OF BUSINESS OR INDUSTRY: (Westinghouse)
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Vernon Wiff
14. MOTHER'S MAIDEN NAME: Nellie Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Nellie Wiff
ADDRESS: 1828 E. Chase St.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-cerebral Injuries
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

E819.4

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): point 5 marker Jones Falls Expressway, E. of the 1 11-02

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 7 '67 11:20 P.M.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Passenger in auto-fixed object accident

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/8/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: Jan 11 1967
23C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
23D. LOCATION (City, town, or county) (State): Arbutus Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 8 1967
24B. NAME OF REGISTRAR: Charles E. Parker
24C. FUNERAL DIRECTOR: Frank T. Elliker
ADDRESS: 1299 N. Carlin St

VS 151-REV. 1/1/65

N 85-6.2

1

W-325

67 0178

BALTIMORE CITY HEALTH DEPARTMENT

67 0178

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): McKinley Watson, Jr.

2. DATE AND HOUR PRONOUNCED DEAD: 1/2/67 1:15 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-06

D. STREET ADDRESS (If rural, give location): 1620 N. Regester St.

5. SEX: male

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 1959

9. AGE (In years last birthday): 7

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: McKinley Watson

14. MOTHER'S MAIDEN NAME: Joyce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: McKinley Watson Sr

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E802X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): railroad tracks

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Broadway overpass 8-07

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 2 (Year) 66 (Hour) 12:34p m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?: struck by train while playing on tracks

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Jan 6/67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem.

23D. LOCATION (City, town, or county) (State): A.A. County Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: Boyd T. Eckerson

ADDRESS: 1829 N. Carey St

VS 151-REV. 1/67

S-520

67 0179

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0179

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Lawrence E Simms

2. DATE AND HOUR OF DEATH: January 7, 1967 | 12:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

14-52

D. STREET ADDRESS (If rural, give location): 652 Pitcher Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Oct. 6, 1918

9. AGE (In years last birthday): 48

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawrence Simms

14. MOTHER'S MAIDEN NAME: Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): Yes

(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorothy Simms-wife

ADDRESS: same

MEDICAL CERTIFICATION

18. 322.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cardiorespiratory arrest

DUE TO

(B) 1) Uremia

DUE TO 2) Epilepsy

(C) 3) alcoholism

INTERVAL BETWEEN ONSET AND DEATH: /

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 2, 1967 to January 7, 1967, that (I) (we) last saw the deceased alive on January 7, 1967 and that in (my) (our) opinion death occurred on the date and hour and ~~from the causes stated above.~~ (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L Carrillo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: January 7, 1967

23C. PHYSICIAN'S NAME (Type): Carrillo M.D.

23D. ADDRESS: 1514 Division Street-Baltimore 17, Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: National Cemetry

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

1
D-252

67 0180

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0180

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MABEL DICKENS

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 8:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2110 Boone Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2110 Boone Street

9-08

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro	Married	4-15-1915	55				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Public	Whitaker, N.C.	U.S.A.

13. FATHER'S NAME: Moses Bullock

14. MOTHER'S MAIDEN NAME: Alice Lee Bryant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 239-60-0479

17. INFORMANT: James Dickens

ADDRESS: R.I Box 292X Battlesboro N.C.

MEDICAL CERTIFICATION

E903.6

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pulmonary thromboemboli complicating fracture of left fibula

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Slade Street

6-8-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-13-66 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Slipped on ice and fell

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	1-8-67	New Mt. Zion Cemetery	Whitaker, N.C.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Farley	Randolph J. Coolick	2431 E. Oliver St

VS 151-REV. 1/1/65

N 823.2

48-30-50 ED 10-500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0181 Registered No. 67 0181

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES CONWAY

2. DATE AND HOUR OF DEATH: 1/6/67 2 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 7-09
D. STREET ADDRESS (If rural, give location): 943 N. Bond St.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 4-29-1896
9. AGE (In years last birthday): 70
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Conway
14. MOTHER'S MAIDEN NAME: Margaret

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-10-1258-A
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.
ADDRESS: # 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2-7/65
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: same
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/14 1966 to 1/6 1967, that (I) ~~(we)~~ last saw the deceased alive on 1/5 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: James J. Corkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/6/67
23C. PHYSICIAN'S NAME (Type): James T. Corkins M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Anne Arundel Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Taylor
25C. FUNERAL DIRECTOR: Randolph J. Codlick
ADDRESS: 2431 E. Oliver St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
E-355

67 0182

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0182

1. NAME OF DECEASED (Type or Print): WILLIS or Willie E. EDMONDS

2. DATE AND HOUR PRONOUNCED DEAD: January 3, 1967 11:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

8-03

D. STREET ADDRESS (If rural, give location): 2709 E. Federal Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Colored	Married	5-11-1921	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Steel Co.	Littleton, N.C.	U.S.A.

13. FATHER'S NAME: Simon Edmonds

14. MOTHER'S MAIDEN NAME: Lizzie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W.2.		Clara Edmonds	2709 E. Federal St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E981X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot Wounds of Chest

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Alley

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1508 Ashland Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 3 '67 11:20 P.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Was shot in chest

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/4/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	1-6-67	Zion Hill Cemetery	Littleton, N.C.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Farley M.D.	Randolph J. Collick	2431 E. Oliver St.

VS 151-REV. 1/1/65

N875.4

X-520

BIRTH NO. 67 0183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0183

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Robert C. Young

2. DATE AND HOUR OF DEATH: 1/8/67 19.25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto - City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 3517 Rosekemp Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-2-19
9. AGE (In years last birthday): 47
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.
10B. KIND OF BUSINESS OR INDUSTRY: Ft. Meade, Md. Post Engineer
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Young
14. MOTHER'S MAIDEN NAME: Lucinda - Ampbly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: 219-12-6029
17. INFORMANT: Hosp. Chart — ADDRESS: Md Gen. Hosp

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac Arrest — ½ Hr
DUE TO
(B) Myocardial Infarction — 4 Hrs
DUE TO
(C) Arteriosclerosis — 15 Yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6:30 P.M. 1/8 1967 to 9:25 P.M. 1/8 1967, that (I) (we) last saw the deceased alive on 1/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: David E. Zickafoose M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/8/67
23C. PHYSICIAN'S NAME (Type): David E. Zickafoose M.D.
23D. ADDRESS: Maryland Gen. Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1-12-67
24C. NAME of CEMETERY or CREMATORY: Northumberland Mem. Park
24D. LOCATION (City, town, or county) (State): Shamokin. Penna.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc — ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-6

BIRTH NO. 67 0184

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0184

1. NAME OF DECEASED (Type or Print): MARY Florence DWYER

2. DATE AND HOUR OF DEATH: 1-7-67 | 11:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MONTEBELLO STATE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-03

D. STREET ADDRESS (If rural, give location): 3101 BATAVIA AVE.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED

8. DATE OF BIRTH: 12-18-79

9. AGE (In years last birthday): 87

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: Hess Ret. Sales Lady

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: ALBERT DWYER

14. MOTHER'S MAIDEN NAME: Margaret HUGHES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-5903A

17. INFORMANT: HOSPITAL RECORD ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC HEART DISEASE

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL THROMBOSIS — 1 MONTH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-5 1967 to 1-7 1967, that (I) (we) last saw the deceased alive on 1-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Irving L. Cooperstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-7-67

23C. PHYSICIAN'S NAME (Type): Irving L. Cooperstein M.D.

23D. ADDRESS: MONTEBELLO STATE HOSPITAL, BALTO. MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: I/10/67

24C. NAME of CEMETERY or CREMATORY: Mt. Olivet Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. Balto., Md. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0185 Registered No. 67 0185

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MICHAEL A. SCHINDLER

2. DATE AND HOUR OF DEATH: January 6, 1967 11:30 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #18 9-03

D. STREET ADDRESS (If rural, give location): 706 Melville Ave.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 3/2/1896

9. AGE (In years last birthday): 70

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Internal Rev. Service

10B. KIND OF BUSINESS OR INDUSTRY: US GOVT.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alois Schindler

14. MOTHER'S MAIDEN NAME: Rosa Rhoeder

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): W W 1

16. SOCIAL SECURITY NO.: 213-40-0616

17. INFORMANT: Mr. Donald T. Cronin, 406 Water St. 21202 ADDRESS

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary Embolism — 11 days

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease — 5 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 12-21 19 66 to 1-6 19 67, that (I) (~~we~~) last saw the deceased alive on 1-6 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Philip D. Flynn M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-7-67

23C. PHYSICIAN'S NAME (Type): Philip D. Flynn M.D.

23D. ADDRESS: 11 E. Chase St., 21202

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment

24B. DATE: 1/9/67.

24C. NAME of CEMETERY or CREMATORY: Lorraine Mausoleum

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. 5305 Harford Rd. #14 ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

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G-534

BIRTH NO. 67 0186

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0186

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DOROTHY M. GINDLESPERGER

2. DATE AND HOUR PRONOUNCED DEAD: January 7, 1967 5:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore #6 27-34
D. STREET ADDRESS (If rural, give location): 5421 Biddison Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: August 5, 1916.
9. AGE (In years last birthday): 50
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? McNeil
14. MOTHER'S MAIDEN NAME: Louise Columbo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 214-03-3695
17. INFORMANT: Mr. Curtis Gindlesperger
ADDRESS: (Same)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure
DUE TO
(B) Cirrhosis of Liver
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/11/67.
23C. NAME of CEMETERY or CREMATORY: Oaklawn Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Fahey M.D.
24C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 151-REV. 1/1/65

K-642

BIRTH NO. 67 0187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0187

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): STELLA KOURLESIS

2. DATE AND HOUR OF DEATH: January 8, 1967. 11:44 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #14 27-38
D. STREET ADDRESS (If rural, give location): 5801 Willowton Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: August 30, 1882.
9. AGE (In years last birthday): 84
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Stratakos
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-12-2950A
17. INFORMANT: Mrs. Helen Doukas, 1621 Ramblewood Rd. #12
ADDRESS:

MEDICAL CERTIFICATION

18. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial infarction — 1 hr
DUE TO
(B)
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 19 67 to January 8 19 67, that (I) ~~(we)~~ last saw the deceased alive on January 7 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: A. Allan Spier M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/9/67
23C. PHYSICIAN'S NAME (Type): A. Allan Spier M.D.
23D. ADDRESS: 1501 Pentridge Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/67.
24C. NAME of CEMETERY or CREMATORY: Greek Orthodox Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214
ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0188 Registered No. 78648

M.E. CASE NO. 67 0188

1. NAME OF DECEASED (Type or Print): PUTENS, Mary (Putens Mary)

2. DATE AND HOUR OF DEATH: Jan-9/1967 3 20/2 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 21214
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 2763
D. STREET ADDRESS (If rural, give location): 2915 Ruckert Ave

5. SEX: F
6. RACE: W
7. ~~MARRIED~~, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 6/27/84 (82)
9. AGE (In years last birthday): 82
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ferdinand Unger
14. MOTHER'S MAIDEN NAME (CHRISTINA Ruhl): Christina Ruhl

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lorraine Putens ADDRESS 2915 RUECKERT

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rt Bundle Branch Block & coronary occlusion

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No.
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/21 1966 to 1/9 1967, that (I) (we) last saw the deceased alive on 3:20 pm Jan 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chang Koe Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: Franklin Square Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: 1-12-67
24C. NAME of CEMETERY or CREMATORY: Moreland Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D. BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc ADDRESS Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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67 0189

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0189

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Melvin John Bafford

2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 11:36 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodlawn 53-

D. STREET ADDRESS (If rural, give location): 6107 Meadow Ave.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	Married	Oct. 20, 1916	50				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Warehouseman	Fruehauf Trailer Company	Baltimore, Maryland	

13. FATHER'S NAME: James Bafford

14. MOTHER'S MAIDEN NAME: Marcel Carwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	World War II	217-09-6521	Mrs. Neva Eileen Bafford	same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/12/1967	Baltimore National Cemetery	Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Farley, M.D.	Wm. J. Tichnor & Sons	Balto. Md. North Ave.

VS 151-REV. 1/1/65

1
H-543

67 0190
BIRTH NO.
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0190

1. NAME OF DECEASED (Type or Print): EVERETT A. HAMILTON

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 2:12 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-05
D. STREET ADDRESS (If rural, give location): 4108 Curtis Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 2/18/1910
9. AGE (In years last birthday): 56
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipfitter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Portland, Maine
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William J. Hamilton
14. MOTHER'S MAIDEN NAME: Elizabeth Doherty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. William G. Hamilton
ADDRESS: Portland, Maine

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/7/67

23A. BURIAL CREMATION, REMOVAL (Specify): Removal
23B. DATE: 1/9/1967
23C. NAME of CEMETERY or CREMATORY: Forest City Cemetery
23D. LOCATION (City, town, or county) (State): South Portland, Maine

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Wm. J. Tichner & Sons
ADDRESS: Butte, Md. North 1 Pa.

VS 151-REV. 1/1/65

1-4-408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0191 Registered No. 67 0191

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MRS HILL BEULAH Marie

2. DATE AND HOUR OF DEATH: 1.6.1967 8 20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSP.

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1-05

D. STREET ADDRESS (If rural, give location): 116 S COLLINGTON AVE. (31)

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 6.20.90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: John FRED MILLER

14. MOTHER'S MAIDEN NAME: LOUISE M. EULER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-09-5952

17. INFORMANT: Dr. K-M Anandaiah ADDRESS: Church home & hospital

MEDICAL CERTIFICATION

18. I 204.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Leukaemia — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

(B) pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12.27.1966 to 1.6.1967, that (I) (we) last saw the deceased alive on 1.6.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: K-M. Anandaiah M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): K-M. ANANDAIAH M.D.

23D. ADDRESS: Church home & hospital Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/9/67

24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Woodlawn, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Wm. J. Pickner & Sons, Inc. ADDRESS: North & Fremont Ave. 21217

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

V-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0192 Registered No. 67 0192

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Rosalie Evans Van Metre

2. DATE AND HOUR OF DEATH: Jan. 6, 1967 11:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 343 Tunbridge Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12

D. STREET ADDRESS (If rural, give location): 343 Tunbridge Road

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8/24/1922

9. AGE (In years last birthday): 44

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry C. Evans

14. MOTHER'S MAIDEN NAME: Eleanor O'Donovan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-22-0533

17. INFORMANT: Dr. Thomas E. Van Metre, Jr. ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I 170 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma — 3 mon.

DUE TO

(B) Carcinoma breast — 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from October 1950 to January 6 1967, that (I) ~~(we)~~ last saw the deceased alive on January 2 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: C. Holmes Boyd M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12/7/67

23C. PHYSICIAN'S NAME (Type): C. Holmes Boyd M.D.

23D. ADDRESS: 24 E. Eager St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/9/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: H. J. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0193 Registered No. 67 0193

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clara H. Adams

2. DATE AND HOUR OF DEATH: January 6, 1967 | 5 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Pine Ridge Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson 53-00

D. STREET ADDRESS (If rural, give location): 1004 Cloverlea Road

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 10/1/1884

9. AGE (In years last birthday): 82

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Hoffman

14. MOTHER'S MAIDEN NAME: Louise Kinsley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-05-0965

17. INFORMANT: Mrs. Kathryn A. Alford

ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 442X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio vascular renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 8 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this~~ hospital) attended the deceased from 1940 19 to 1-6-47 19, that (I) (~~we~~) last saw the deceased alive on 12-19-44 19 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: C. W. Peake M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-6-47

23C. PHYSICIAN'S NAME (Type): Clarence W. Peake M.D.

23D. ADDRESS: 4508 Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/9/1967

24C. NAME of CEMETERY or CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Falkner

25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-3202

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0194 Registered No. 67 0194

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SARAH FLORENCE EDES

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 7:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4016 Carisle Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 4016 Carisle Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	12/9/1887	79		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Baltimore, Maryland	USA

13. FATHER'S NAME: Abraham Greider

14. MOTHER'S MAIDEN NAME: Lily ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-01-7191

17. INFORMANT: D Caleb R. Kelly, Jr. ADDRESS: 310 Tower Bldg.

MEDICAL CERTIFICATION

1B. 443X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/9/1967	Druid Ridge	Pikesville, BaltoCo., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 9 1967	Robert E. Fisher, M.D.	H.W. Jenkins & Sons Co.	4905 York Rd. Balto. 12, Md.

0 1 2 3

VS 151-REV. 1/1/65

B-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0195 Registered No. 67 0195

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Stella A. Besche

2. DATE AND HOUR OF DEATH: Jan. 6, 1967 | 6 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Gould Convalescent Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-01

D. STREET ADDRESS (If rural, give location): 4212 Belmar Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug. 7, 1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: — Geisenkotter

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 219-30-0764

17. INFORMANT: Anthony H. Besche ADDRESS: 4212 Belmar Ave. - 21206

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 334X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic cerebro cardio vascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 19 64 to 1/6 19 67, that (I) (~~we~~) last saw the deceased alive on 1/3 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Paul G. Mueller M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): Paul G. Mueller M.D.

23D. ADDRESS: 6411 Belair Rd

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-67

24C. NAME of CEMETERY or CREMATORY: Holy Cross Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 9 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: John C. Miller Inc. ADDRESS: 6415 Belair Road. - 21206

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-18167 67 0196

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0196

1. NAME OF DECEASED (Type or Print): LILLIAN SPENCER

2. DATE AND HOUR OF DEATH: 1-6-'67 | 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 315 St. Victor St

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 7-7-65
9. AGE (In years last birthday): 1½ y
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jos Walker
14. MOTHER'S MAIDEN NAME: Patricia Fox

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mother
ADDRESS: same

MEDICAL CERTIFICATION

18. 756.2

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Biliary Cirrhosis — 1½ yrs
DUE TO
(B) Biliary Atresia — 1½ yrs
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Dec, 1965
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Biliary Atresia
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-5-67 19 67 to 1-6 19 67, that (I) (we) last saw the deceased alive on 1-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-6-67
23C. PHYSICIAN'S NAME (Type): B. C. VENERACION JR. M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-7-67
24C. NAME of CEMETERY or CREMATORY: MT. OLIVET
24D. LOCATION (City, town, or county) (State): BALTIMORE, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Falkenham
25C. FUNERAL DIRECTOR: Geo. A. Schwab Funeral Home, Francis W. Miller
ADDRESS: 2101 Frederick Ave

VS 150-REV. 1/1/65

F-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0197
M.E. CASE NO. 67 0197
Registered No. 67 0197

1. NAME OF DECEASED (Type or Print): JAMES FOXWELL JR.

2. DATE AND HOUR OF DEATH: 1/2/66 1967 11:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Dorchester Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CAMBRIDGE 39-13
D. STREET ADDRESS (If rural, give location): 202 E. APPLEBY AVE

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 2/9/45
9. AGE (In years last birthday): 21
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COLLOTEX MAN
10B. KIND OF BUSINESS OR INDUSTRY: AUTO. SHOP
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES FOXWELL SR.
14. MOTHER'S MAIDEN NAME: BETTY JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-42-8270
17. INFORMANT
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkin's Disease — INTERVAL BETWEEN ONSET AND DEATH: 16 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 2 1966 to Jan. 2 1966, that (I) (we) last saw the deceased alive on Jan 2 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zalman S. Agus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Jan. 2, 1966
23C. PHYSICIAN'S NAME (Type): ZALMAN S. AGUS M.D.
23D. ADDRESS: UNIVERSITY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/5/67
24C. NAME of CEMETERY or CREMATORY: Dorchester Mem. Park
24D. LOCATION (City, town, or county) (State): Cambridge Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967
25B. NAME OF REGISTRAR: Robert E. Falkner
25C. FUNERAL DIRECTOR: Norman R. Thomas Jr.
ADDRESS: Cambridge Md. 2161

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0198

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LINETTE SCOTT

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 3:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 520 Gold Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03

D. STREET ADDRESS (If rural, give location): 520 Gold Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Feb 22. 1910

9. AGE (In years last birthday): 56

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Nottoway Co. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Anderson Crawley

14. MOTHER'S MAIDEN NAME: Lunette Crawley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-22-3455

17. INFORMANT: Earl Scott ADDRESS: 2108 Division St. Baltimore Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, MD.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/7/67

23A. BURIAL CREMATION, REMOVAL (Specify): Removal-Burial

23B. DATE: JAN 11, 1967

23C. NAME of CEMETERY or CREMATORY: Spring Hill Church

23D. LOCATION (City, town, or county) (State): Blackstone, Nottoway Va

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Fauber

24C. FUNERAL DIRECTOR: Florance Fun Home ADDRESS: Box 184 Blackstone Va

VS 151-REV. 1/1/65

1

G-350

BIRTH NO. 67 0199

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0199

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA HIMMEN GOODEN

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 1:25 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 4602 Schenley Road

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14

D. STREET ADDRESS (If rural, give location): 4602 Schenley Road

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug 19 1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick Himmen

14. MOTHER'S MAIDEN NAME: Mary Casper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Enos P. Gooden

ADDRESS: 4602 Schenley Rd

MEDICAL CERTIFICATION

1B. 420.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Heart Disease.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-9-67

23C. NAME of CEMETERY or CREMATORY: Lorraine Park Cem

23D. LOCATION (City, town, or county) (State): Woodlawn, Balto Co Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 9 1967

24B. NAME OF REGISTRAR: Robert E. Fahrney

24C. FUNERAL DIRECTOR: Burgee Funeral Home

ADDRESS: 3637 Falls Rd

By Horace M. Burgee Jr

VS 151-REV. 1/1/65

F-62

BIRTH NO. 67 0200

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0200

1. NAME OF DECEASED (Type or Print): Willie E. Frazier

2. DATE AND HOUR OF DEATH: January 7, 1967 12:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 517 W. Mosher Street

14-02

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: Jan 5, 1896
9. AGE (In years last birthday): 71
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Frazier
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 220-12-8848
17. INFORMANT: Mary White-sister-in-law
ADDRESS: 517 Mosher St same

MEDICAL CERTIFICATION

1B. 421.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pulmonary embolism - 10'
DUE TO
(B) 1) Aortic insufficiency -
DUE TO 2) heart failure,
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 1, 1966 to January 7, 1967, that (I) (we) last saw the deceased alive on January 7, 1967 and that in (my) (our) opinion death occurred on the date and ~~hour and from the causes stated above~~. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L C Carrillo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: January 7, 1967
23C. PHYSICIAN'S NAME (Type): Carrillo M.D.
23D. ADDRESS: 1514 Division Street-Baltimore 17, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Fuller M.D.
25C. FUNERAL DIRECTOR: Earl Gilmore
ADDRESS: 1827 W. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-421

67 0201

BIRTH NO. 67-00553

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0201

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Girl Willoughby

2. DATE AND HOUR OF DEATH: 1/6/67 — 1245 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-05

D. STREET ADDRESS (If rural, give location): 550 N. BROADWAY 21205

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married

8. DATE OF BIRTH: 1/5/67

9. AGE (In years last birthday): If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 4 Min.: 35

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: WILLIAM F. WILLOUGHBY

14. MOTHER'S MAIDEN NAME: DAISY GARTH

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 77351

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 4 3/60

DUE TO

(B) Respiratory Distress Syndrome

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/5/ 1967 to 1/6 1967, that (I) (we) last saw the deceased alive on 1/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard D. Bland M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): RICHARD D. BLAND M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: The Johns Hopkins Hosp.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farkas M.D.

25C. FUNERAL DIRECTOR: HOSPITAL DISPOSAL

ADDRESS:

VS 150-REV. 1/1/65

M-500

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0202 Registered No. 67 0202

M.E. CASE NO. Donald Z. Mann

1. NAME OF DECEASED (Type or Print) Donald Z Mann

2. DATE AND HOUR OF DEATH 1/7/67 - 1200 Noon M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hanover. V-35
D. STREET ADDRESS (If rural, give location) Hill View House

5. SEX MALE 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH 12/19/25 9. AGE (In years last birthday) 41 If Under 1 Yr. Months Days 18 If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Co. 10B. KIND OF BUSINESS OR INDUSTRY Alwine Brick Co. 11. BIRTHPLACE (State or foreign country) York 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Horace N. Mann 14. MOTHER'S MAIDEN NAME Dorothy Zimm

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes (If yes, give war or dates of service) W.W. 2 16. SOCIAL SECURITY NO. 199-14-0401 17. INFORMANT Margaret H. Mann ADDRESS 220 N. Stephen Pl. Hanover Pa.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 237 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) BRAIN TUMOR. — INTERVAL BETWEEN ONSET AND DEATH: 4 years

DUE TO

(B) Hemorrhagic congestion of the lungs

DUE TO

(C) — 4.K. Born.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 1/6/67. 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Decompression - Evacuation for Suspected Brain Tumor 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/4/ 1967 to 1/7 1967, that ~~(I)~~ (we) last saw the deceased alive on 1/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE David S. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED 1/7/67

23C. PHYSICIAN'S NAME (Type) DAVID S. SCHWARTZ M.D. 23D. ADDRESS UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1/ 10/67 24C. NAME of CEMETERY or CREMATORY Rest Haven Cemetery 24D. LOCATION (City, town, or county) Hanover, (State) Pa.

25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR J. F. Eline & Sons ADDRESS Reisterstown, Md.

VS 150-REV. 1/1/65 JAN 10 1967 Robert E. Fahey

B-63 1

67 0203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0203

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BROADERS, FRANK HOFFMAN

2. DATE AND HOUR OF DEATH: 1-5-67 8:30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE UNION MEMORIAL HOSP

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): PIKESVILLE 53-00

D. STREET ADDRESS (If rural, give location): 11 BRIGHTSIDE AVE

5. SEX: M

6. RACE: CAUC

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 6-16-86

9. AGE (In years last birthday): 80

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: UNKN

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK H. BROADERS, JR.

14. MOTHER'S MAIDEN NAME: MARY CLARA BAKER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-8454A

17. INFORMANT: WIFE

ADDRESS: 11 Brightside Ave. Pikesville 8, Md. Mrs. Louise F. Broaders

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNEUMONIA

DUE TO

(B) ASHD

DUE TO

(C) COMPLETE HEART BLOCK (IMPLANTED PACE MAKER)

INTERVAL BETWEEN ONSET AND DEATH: 19 DAYS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pyelonephritis bilateral with PO calculus

19A. DATE OF OPERATION: NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: NONE

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): NONE

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): NONE

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): NONE

21E. INJURY OCCURRED: White At Work ☐ Not While At Work ☐ NO

21F. HOW DID INJURY OCCUR? NO

22. I certify that ~~(I)~~ (~~this hospital~~ THIS HOSP) attended the deceased from 12-17-66 19 to 1-5 19 67, that (I) (~~we~~) last saw the deceased alive on 1-5- 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Jeff Parker M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-5-67

23C. PHYSICIAN'S NAME (Type): JEFF PARKER, M.D. Jeff Parker

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL Hosp

24A. BURIAL CREMATION REMOVAL (Specify): Burial

24B. DATE: Jan. 9, 1967

24C. NAME OF CEMETERY OR CREMATORY: Ridgelawn Cemetery

24D. LOCATION (City, town, or county) (State): Pikesville 8, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farber M.D.

25C. FUNERAL DIRECTOR: Frank H. Howell

ADDRESS: Pikesville

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-263

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0204 Registered No. 67 0204

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): SIEGERT, WILLIAM M.

2. DATE AND HOUR OF DEATH: 1-9-67 | 9:15 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 20-06
D. STREET ADDRESS (If rural, give location): 3007 FREDERICK AVE, ~~21229~~ 21223

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 7-20-96
9. AGE (In years last birthday): 70 — If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PLUMBING
10B. KIND OF BUSINESS OR INDUSTRY: PLUMBING
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM J. Frederick Siegert
14. MOTHER'S MAIDEN NAME: IDA LEWIS
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 216 07 2257
17. INFORMANT: ST AGNES HOSPITAL RECORDS, WILKENS AND CATON AVES. ADDRESS: 21229

MEDICAL CERTIFICATION

1B. 24 hr I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary edema
DUE TO
(B) Chronic Asthma and
DUE TO
(C) emphysema

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-8- 1967 to 1-9- 1967, that (I) (we) last saw the deceased alive on 1-9- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-9-67
23C. PHYSICIAN'S NAME (Type): M. HEREDIA M.D.
23D. ADDRESS: CATON & WILKENS AVE. BALTO MD

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Memorial Pk.
24D. LOCATION (City, town, or county) (State): Wash. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: John J. Gowan + Son
ADDRESS: 901 Lee Hollins St. Balto 23, Md.

VS 150-REV. 1/1/65

B-5001

BIRTH NO. 67 0205

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0205

1. NAME OF DECEASED (Type or Print): Warner Carroll Beane

2. DATE AND HOUR OF DEATH: January 6, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2715 N. Charles St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 12-06

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2715 N. Charles St.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: 9-13-1903

9. AGE (In years last birthday): 64

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor

10B. KIND OF BUSINESS OR INDUSTRY: Balto. Transit Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Lombard Beane

14. MOTHER'S MAIDEN NAME: Viola C. Dunaway

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-0452

17. INFORMANT: JAMES L. CURRIE ADDRESS: KILMARNOCK, VA. HA

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 157 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Cancer of pancreas — 1 1/2 yrs

ANTECEDENT CAUSES

(B) DUE TO:

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C):

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: Oct 8 1965

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca of pancreas

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 1965 to Jan 6 1967, that (I) (we) last saw the deceased alive on Jan 6 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Elliott Fishel M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan 6, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Elliott R. Fishel M.D.

23D. ADDRESS: Pratt & Eutaw Sts. Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-8-67

24C. NAME of CEMETERY or CREMATORY: White Marsh Meth Ch.

24D. LOCATION (City, town, or county) (State): Brookvale, Va.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Falkenstein

25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc. ADDRESS: 6500 York Rd. Baltimore, Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-41-33 DH 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67-00046 67-0206 Registered No. 67 0206

M.E. CASE NO. Mother's Case # 30-07-57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Baby Boy Thomas, [redacted]

2. DATE AND HOUR OF DEATH: 1-1-67 10 45 Am M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 1518 Tractin St. #21217

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single never
8. DATE OF BIRTH: 1-1-67
9. AGE (In years last birthday): —
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: 9 Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Delores Thomas

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: RECORDS; Mother
ADDRESS: BCH 4940 Eastern Avenue Baltimore, Maryland #21224

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 753.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) apnea — 7.05 min.
DUE TO
(B) microcephaly with cyclopia — 9 hrs
DUE TO
(C) absence of nose + — 9 hrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: none
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ~~12/31~~ 1/1/67 19 67 to 1/1 19 67, that (I) (we) last saw the deceased alive on 1/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ann Louise Silver M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/1/67
23C. PHYSICIAN'S NAME (Type): Ann Louise Silver M.D.
23D. ADDRESS: 4940 Eastern Avenue Balto., Md. #21224 Baltimore City Hospitals.

24A. BURIAL CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1-4-67
24C. NAME of CEMETERY or CREMATORY: Baltimore City Hospitals
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: 0
ADDRESS: HOSPITAL DISPOSAL

VS 150-REV. 1/1/65

R.4001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0207 Registered No. 67 0207

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Riley

2. DATE AND HOUR OF DEATH: 1/6/67 3 27 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bolton Hill Nursing Home Layfette and John STs.

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Edgewater 52-00
D. STREET ADDRESS (If rural, give location): Route #3 Box 622

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: April 12, 1875
9. AGE (In years last birthday): 91
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Riley
14. MOTHER'S MAIDEN NAME: Jane Unk.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Margaret R. Duffy ADDRESS: Same as #4

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Immediate

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Dec 12 19 66 to Jan 6 19 67, that (I) (~~we~~) last saw the deceased alive on Jan 5 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Stanley Z. Felsenberg M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/6/67
23C. PHYSICIAN'S NAME (Type): STANLEY Z. FELSENBERG M.D.
23D. ADDRESS: 1129 E. Baltimore St. Baltimore Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-67
24C. NAME of CEMETERY or CREMATORY: Congressional Cemetery
24D. LOCATION (City, town, or county) (State): Washington, D.C.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc. ADDRESS: 1217 St. Paul St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-60

BIRTH NO. 67 0208

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0208

1. NAME OF DECEASED (Type or Print): Hubert T. Carroll, JR.

2. DATE AND HOUR OF DEATH: 1/6/67 | 8 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: HARFORD

C. CITY OR TOWN (If outside city limits, write RURAL and give township): EDGEWOOD HARFORD Co.

D. STREET ADDRESS (If rural, give location): 2004 MORGAN STREET 62-00

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-16-24

9. AGE (In years last birthday): 42

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Boothton, Alabama

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HUBERT T. CARROLL, Sr.

14. MOTHER'S MAIDEN NAME: INEZ DE MENT

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWII & Korean

16. SOCIAL SECURITY NO.: 416-20-2058

17. INFORMANT: Mrs. W.L. Sanderson, 111 Westbrook Road, ADDRESS Hueytown, Alabama

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 4.5 / X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardiac Arrest

DUE TO

(B) Anoxia + Hypotension

DUE TO

(C) Dissecting Aneurysm

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/2/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Dissecting Aneurysm

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1/2/ 1967 to 1/6/ 1967, that (I) (~~we~~) last saw the deceased alive on 1/6/ 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Fremont P. Wirth, Jr. M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): FREMONT P. WIRTH JR. M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Removal

24B. DATE: Jan. 8, 1967

24C. NAME of CEMETERY or CREMATORY: Angwin Funeral Home

24D. LOCATION (City, town, or county) (State): Fairfield Alabama

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Howard K. McComas & Son, ADDRESS Abingdon, Md. 21009

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200

BIRTH NO. 67 0209

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0209

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): MARGARET HOOK

2. DATE AND HOUR OF DEATH: 1-7-67 | 4:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Melchor Nursing Home 90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-31

D. STREET ADDRESS (If rural, give location): 5352 Reisterstown Road

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 2/26/1886

9. AGE (In years last birthday): 80

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Joseph Hook

14. MOTHER'S MAIDEN NAME: Josephine Boggs

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Harold C. Morgan

ADDRESS: 5352 Reisterstown Road

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Congestive Heart Failure

DUE TO

(B) Arteriosclerotic C.V. Disease

DUE TO

(C) Generalized Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 8-2- 1965 to 1-7- 1967, that (I) (we) last saw the deceased alive on 1-7- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar Valle Cavero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-7-67

23C. PHYSICIAN'S NAME (Type): CESAR VALLE CAVERO M.D.

23D. ADDRESS: 8629 Liberty Rd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/10/67

24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State): Pikesville, Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Vernon Lemmon

ADDRESS: 4611 Park Heights Ave.

VS 150-REV. 1/1/65

F-555 1

BIRTH NO. 67 0210

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0210

1. NAME OF DECEASED (Type or Print): JULIAN FENNEMAN

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 | 3:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 9 S. Carey Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03

D. STREET ADDRESS (If rural, give location): 9 S. Carey Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Single	12/24/1882	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Baltimore Md.	U. S. A.

13. FATHER'S NAME: Henry Fenneman

14. MOTHER'S MAIDEN NAME: Gertrude ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): ✓ (If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: 218-09-8331

17. INFORMANT: Mrs Virginia Farrar ADDRESS: above

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	1/9/67	Glen Haven Cem.	Ritchie Hwy.	Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Farley, MD	John J. Cowan + Son Inc	901 St Hollins 23 Md.

VS 151-REV. 1/1/65

5-560

BIRTH NO. 67 0211

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 29760 67 0211

1. NAME OF DECEASED (Type or Print): SWANNER, Margaret

2. DATE AND HOUR OF DEATH: 1:35 Am Jan 8/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital, Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: A.A.C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 52-00

D. STREET ADDRESS (If rural, give location): 203 Walton Ave

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 11/18/1898

9. AGE (In years last birthday): 68

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael ~~Falkenham~~ FALKENHAM

14. MOTHER'S MAIDEN NAME: BERTHA Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No.

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B) Ventricular fibrillation

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/28 1966 to 1/8 1967 that (I) (we) last saw the deceased alive on 1:35 Am 1/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chang Kue Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/8/67

23C. PHYSICIAN'S NAME (Type): M.D.

23D. ADDRESS: Franklin Square Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-12-67

24C. NAME of CEMETERY or CREMATORY: OAKLAWN

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Tankey M.D.

25C. FUNERAL DIRECTOR: O'Neill 130 E. Fort Ave.

ADDRESS: 21230

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-651

67 0212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0212

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BRINKMAN MARY

2. DATE AND HOUR OF DEATH: 5th January '67 6 25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP BALTIMORE

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-07

D. STREET ADDRESS (If rural, give location): 3939 ROLAND AVENUE

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-12-93

9. AGE (In years last birthday): 73

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-2914

17. INFORMANT: GEO. R. BRINKMAN ADDRESS: 3910 ROLAND AVE.

MEDICAL CERTIFICATION

1B. 434.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CONGESTIVE HEART FAILURE.

~~DUE TO~~

(B) TERMINAL ASPIRATION

~~DUE TO~~

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-27 1966 to 1-5 1967, that (I) (we) last saw the deceased alive on 1-5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjofur Bjornsson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON

23D. ADDRESS: UNION MEMORIAL HOSP

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/9/67

24C. NAME of CEMETERY or CREMATORY: LORRAINE

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: [illegible]

ADDRESS: 3612 [illegible] Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

K-620

67 0213

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0213

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ~~Leonard~~ SAMUEL KRAUSS

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 9:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2341 Annapolis Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 25-33

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2341 Annapolis Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Widowed	11-29-1873	93				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor Ret.	B. O. Railroad	Maryland	U.S.A.

13. FATHER'S NAME: Jonathan Krauss

14. MOTHER'S MAIDEN NAME: Margaret Tyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Bernard Pierce ADDRESS: West Chester Pa.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I 1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-9-1967	Brookview Cem.	Rising Sun, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Farley M.D.	Clemon E. McMullen	Rising Sun, Md.

VS 151-REV. 1/1/65

H-536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0214 Registered No. 67 0214

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lela ~~Lelia~~ Henderson

2. DATE AND HOUR OF DEATH: January 3, 1967 | 6:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2828 N. Calvert Street
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 2814 N. Calvert Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	8-15-1882	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	---	Maryland	U.S.A.

13. FATHER'S NAME: Samuel Carey

14. MOTHER'S MAIDEN NAME: Annie Ewell

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	---	None	Miss Anne Henderson	Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-Vascular Disease — months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

422.1

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral Hemorrhage — 2 weeks

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0 NONE	✓	NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 3, 1966 to Jan. 3, 1967, that (I) (we) last saw the deceased alive on Jan. 3, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank N. Ogden M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Jan. 3, 1967.
23C. PHYSICIAN'S NAME (Type): Frank N. Ogden M.D.
23D. ADDRESS: 2701 N. Calvert Street, Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or ~~CREMATORY~~	24D. LOCATION (City, town, or county) (State)
Burial	1-6-1967	Salem Methodist	Pocomoke City, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	26C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Farley M.D.	Robert H. Watson	Pocomoke City, Md.

Robert H. Watson

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-43d

Released by M.E.O.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0215

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X Registered No. 67 0215

1. NAME OF DECEASED (Type or Print): PLATT, FRANK

2. DATE AND HOUR OF DEATH: 1/7/67 11:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: N.Y.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Long Island City V-29

D. STREET ADDRESS (If rural, give location): 2113 or 2568 14th ST.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single ?

8. DATE OF BIRTH: 9/12/1919 XXXXXXXXXXX

9. AGE (In years last birthday): 47 XXXXX

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Citator

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frederick ~~Platt~~

14. MOTHER'S MAIDEN NAME: Mary Turk~~ovic~~

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO. 075-07-8828

17. INFORMANT: Mary Turkovic, 25-61 35th St., New York 11103

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7 19 67 to 1/7 19 67, that (I) ~~(we)~~ last saw the deceased alive on 1/7 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Zalman S. Agus M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): ZALMAN S. AGUS M.D.

23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 11, 67

24C. NAME of CEMETERY or CREMATORY: Flushing Cemetery

24D. LOCATION (City, town, or county) (State): Flushing, New York

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Ave. Baltimore, Maryland 21229

VS 150-REV. 1/1/65

G-362

BIRTH NO. 67 0216

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0216

1. NAME OF DECEASED (Type or Print): Richard R. Goodrich

2. DATE AND HOUR OF DEATH: 1/4/67 9:26p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 St. Agnes Hospital Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25 25-04

D. STREET ADDRESS (If rural, give location): 967 Stoll Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 12/26/1889

9. AGE (In years last birthday): 77

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wire Brush Maker

10B. KIND OF BUSINESS OR INDUSTRY: Pittsburgh Glass Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Marshall Goodrich

14. MOTHER'S MAIDEN NAME: Mary A. Levering

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-05-3006

17. INFORMANT: Mrs. Hannah Goodrich- same

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) ASCVD - ACUTE PULMONARY

DUE TO

(B) EDEMA - PROBABLY MIOCAR

DUE TO

(C) DIAL INFARCTION, ACUTE

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: X [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): JUAN J. CABRERA M.D.

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-1967

24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley

25C. FUNERAL DIRECTOR: George J. Gonce

ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-416

BIRTH NO. 67 0217

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0217

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RENZO C WOLFORD

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 11:38 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-02
D. STREET ADDRESS (If rural, give location): 1036 E. Fort Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): D
8. DATE OF BIRTH: 11-8-02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mech.
10B. KIND OF BUSINESS OR INDUSTRY: W. Md. RR
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Open Diaz
14. MOTHER'S MAIDEN NAME: Lowa Holmes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family - Same
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

581.0

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Confluent bronchopneumonia (right)
DUE TO
(B) Fatty metamorphosis of liver
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Partial
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ Partial and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
DATE SIGNED: January 6, 1967

23A. BURIAL, CREMATION, REMOVAL (Specify): B
23B. DATE: 1/9/67
23C. NAME of CEMETERY or CREMATORY: Glen Haven
23D. LOCATION (City, town, or county) (State): Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
24B. NAME OF REGISTRAR: Robert E. [illegible]
24C. FUNERAL DIRECTOR: [illegible] - 130 E Fort Ave.
ADDRESS:

VS 151-REV. 1/1/65

F-221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0218 Registered No. 67 0218

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Z. Dr. EUGENE FOSTER

2. DATE AND HOUR OF DEATH 1/7/67 3 50 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP. 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTO. CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 9-06
D. STREET ADDRESS (If rural, give location) 3211 The ALAMEDA #18

5. SEX MALE
6. RACE White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED
8. DATE OF BIRTH 12/16/88
9. AGE (In years last birthday) 78
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VETERINARIAN-Semi Retired
10B. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (State or foreign country) Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME JOEL ZUMWALT
14. MOTHER'S MAIDEN NAME MARY WILLETTA Foster (nee Oakjones)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-32-1086
17. INFORMANT WIFE, Aldona Foster, 3211 Almeda ADDRESS

MEDICAL CERTIFICATION

18. 332 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/20 1960 to 1/9 1967, that (I) (we) last saw the deceased alive on 1/7/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) Daniel Cullenson M.D.
23D. ADDRESS 421 Regester Ave

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/11/67
24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) (State) Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 10 1967
25B. NAME OF REGISTRAR [signature]
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3831 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0219 Registered No. 67 0219

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Colwell, Richard Grafton Sr.

2. DATE AND HOUR OF DEATH: January 8, 1967 5:40 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 443 N. Bouldin Street Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-10

D. STREET ADDRESS (If rural, give location): 443 N. Bouldin Street #24

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: Oct. 19, 1906

9. AGE (In years last birthday): 60 yrs.

If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10B. KIND OF BUSINESS OR INDUSTRY: Gas & Elec. Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard C. Colwell

14. MOTHER'S MAIDEN NAME: Mary Matthews

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-05-5703

17. INFORMANT: Elizabeth Finnerty, dght., 624 N. Ellwood Ave. ADDRESS #5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Bronchogenic carcinoma of left lung — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.

DUE TO

(B) acute heart failure, angina

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1966 to Jan 8 1967, that (I) (we) last saw the deceased alive on Jan 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Luther E. Little M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type): Dr. Luther Little M.D.

23D. ADDRESS: 10 W. Madison Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/12/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 3301 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-534

BIRTH NO. 67 0220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0220

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ISAAC SANDLER

2. DATE AND HOUR OF DEATH: 1/4/67 | 9 30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): RANDALLSTOWN 53-00

D. STREET ADDRESS (If rural, give location): 3503 FOXCLIFF COURT

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: 07-14-90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repair

10B. KIND OF BUSINESS OR INDUSTRY: Shoes

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MANUEL SANDLER

14. MOTHER'S MAIDEN NAME: Fannie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-14-1333

17. INFORMANT: Mr. David Sandler, 3503 Foxcliff Court

ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 434.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGESTIVE HEART FAILURE

DUE TO

(B) PULMONARY EDEMA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/26/1966 to 1/4/1967, that ~~(I) (we)~~ last saw the deceased alive on 1/4/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/4/67

23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY M.D.

23D. ADDRESS: Union Memorial Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/6/67

24C. NAME of CEMETERY or CREMATORY: Posvohler Friendly Society

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Faikyne

25C. FUNERAL DIRECTOR: [signature] & Bros

ADDRESS: 601 Reisterstown Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

S-355

67 0221

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0221

1. NAME OF DECEASED (Type or Print): NELSON Bernard SEIDMAN

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 11:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto. Co

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Stevenson 53-00

D. STREET ADDRESS (If rural, give location): Valley Road (Near Stevenson Road)

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: March 25, 1934

9. AGE (In years last birthday): 32

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney

10B. KIND OF BUSINESS OR INDUSTRY: Self-Employed

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Seidman

14. MOTHER'S MAIDEN NAME: Mollie Fleischer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Edna Seidman, ADDRESS: Valley Road (Near Stevenson Road)

MEDICAL CERTIFICATION

1B. E 819.4

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Multiple Traumatic Injuries.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balto. Beltway & Joppa Rd. Overpass.

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 5 (Year) '67 (Hour) A m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Driver of auto into fixed object. 53-00

22. I certify that I held an [ ] Inquiry [ ] Inspection [X] Autopsy and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Charles S. Petty M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/6/67

23C. NAME of CEMETERY or CREMATORY: Hebrew Friendship

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

24B. NAME OF REGISTRAR: R. S. E. Fookes

24C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc., ADDRESS: 6010 Reist., Rd.

0220

VS 151-REV. 1/1/65

N 869.2

M-460 67 0222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0222

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Esther Miller

2. DATE AND HOUR OF DEATH: January 5, 1967 — 6 P.M.

CERTIFICATE AMENDED 3-9-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3411 Springdale Ave

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-38
D. STREET ADDRESS (If rural, give location): 3411 Springdale Ave

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH:
9. AGE (If years last birthday): 89
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph [redacted] Lubsky
14. MOTHER'S MAIDEN NAME: Katie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Samuel Miller — ADDRESS: 5906 Simmonds Ave

MEDICAL CERTIFICATION

1B. 420.1

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) coronary occlusion — Sudden
DUE TO
(B) Hypertension — since 1937
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 20 1925 to Jan 5 1967, that (I) (we) last saw the deceased alive on Jan 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Whitehouse M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/6/66-1967
23C. PHYSICIAN'S NAME (Type): SAMUEL WHITE HOUSE M.D.
23D. ADDRESS: 3960 N. Charles St

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 6/66 67
24C. NAME of CEMETERY or CREMATORY: Beth El Memorial Park
24D. LOCATION (City, town, or county) (State): Randallstown Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Sol Levin & Bros Inc
ADDRESS: 6010 Reisterstown Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 3-9-67 M.H.

S-1356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0223 Registered No. 67 0223

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Alfred Steiner

2. DATE AND HOUR OF DEATH: 1/5/67 9:40 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Montgomery

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Silver Spring 65-00

D. STREET ADDRESS (If rural, give location): 8820 Glenville Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	2/23/02	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guide	Sightseeing	Austria	U. S. A.

13. FATHER'S NAME: Robert Steiner

14. MOTHER'S MAIDEN NAME: Matilde Wehli

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Daisy Gerisl Steiner - wife ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

DUE TO

(B) URINARY TRACT OBSTRUCTION

DUE TO

(C) INVASIVE RECTUM CA — 5 YRS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	Yes	—

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1965 to JAN 5, 1967, that (I) (we) last saw the deceased alive on JAN 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-5-67

23C. PHYSICIAN'S NAME (Type): RAINER M ENGEL M.D.

23D. ADDRESS: JOHNS HOPKINS HOSP, BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/8/67	Park National Memorial	Falls Church, Va.

25A. DATE REC'D BY HEALTH DEPT. JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Talbert M.D.

25C. FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible] Reisterstown Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0224 Registered No. 67 0224

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MRS. LOIS MARY KELLY

2. DATE AND HOUR OF DEATH: Jan. 6 / 67 11:23 A.M. K.R. Miranda

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Church Home and Hospital
(If not in hospital or institution, give street address or location): 35

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: ~~Baltimore~~ Maryland, Balto. Co.
B. COUNTY: 6829 Belclare Rd.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Dundalk, Maryland zone 22
D. STREET ADDRESS (If rural, give location): 6829 Belclare Rd. 53-00

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8/18/17
9. AGE (In years last birthday): 49
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): part time work Clerk,
10B. KIND OF BUSINESS OR INDUSTRY: Reads Drug Store
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: George Rohr (deceased)
14. MOTHER'S MAIDEN NAME: Lillie Donithan (deceased)
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-09-3400
17. INFORMANT: Mr. J. Kelly (Husband) ADDRESS: 6829 Belclare Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute & Subacute Hepatitis; Infectious
DUE TO
(B) G-I hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-1-66 1966 to 1-6 1967, that (I) (we) last saw the deceased alive on 1-6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: A. Kelenko M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-6-67
23C. PHYSICIAN'S NAME (Type): Dr. Paul Harold M.D.
23D. ADDRESS: Church Home & Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan-10-1967
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: JOHN J. DUDA, Dundalk, Maryland 21222 ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-37-14 DH 1H-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 67 0225 Registered No. 67 0225

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nettie Herminau NETTIE HERMINAU

2. DATE AND HOUR OF DEATH: 8 January 1967 | 2:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 31 4940 Eastern Avenue Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): Ave B Box 325 #21219

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 2 October 1891

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George (Deceased)

14. MOTHER'S MAIDEN NAME: Elizabeth (Deceased)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-07-3828B

17. INFORMANT: BCH RECORDS: ADDRESS: 4940 Eastern Avenue Baltimore, Maryland #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atrial Fibrillation

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 25 1966 to Jan 8 1967, that (I) (we) last saw the deceased alive on Jan 8 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alan J Barnes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Jan 8, 1967

23C. PHYSICIAN'S NAME (Type): Alan J. Barnes M.D.

23D. ADDRESS: 4940 Eastern Avenue Baltimore, Maryland #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/12/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: John J. Duda, ADDRESS: 7922 Wise Ave. Dundalk, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-37-15 B
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-300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0226 | Registered No. 67 0226

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dave Scott
Scott, Dave

2. DATE AND HOUR OF DEATH: 1/8/67 | 6 55 a.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Edgemere
53.00
D. STREET ADDRESS (If rural, give location): 38 WILLOW ROAD - 21219

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/11/08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper
10B. KIND OF BUSINESS OR INDUSTRY: Nelson Box Co.
11. BIRTHPLACE (State or foreign country): TENNESSEE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not Known DECEASED
14. MOTHER'S MAIDEN NAME: Not Known DECEASED

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 403-03-1083
17. INFORMANT: RECORDS: BCH, 4940 Eastern Ave. Balto. Md. 21224
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. 433.11
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mesenteric artery Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
DUE TO
(B) Generalized arteriosclerotic cardiovascular disease —
DUE TO
(C) Auricular fibrillation —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia, Peritonitis

19A. DATE OF OPERATION: 1/2/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bowel infarct.
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/25 19 66 to 1/8 19 67, that ~~(I)~~ (we) last saw the deceased alive on 1/8 19 67 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Carl Winterstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/8/67
23C. PHYSICIAN'S NAME (Type): CARL WINTERSTEIN M.D.
23D. ADDRESS: BALTIMORE CITY HOSPITALS
4940 Eastern Avenue, Balto, Md. 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/67
24C. NAME of CEMETERY or CREMATORY: Meadowridge Memorial Park
24D. LOCATION (City, town, or county) (State): Dorsey, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Talbert
25C. FUNERAL DIRECTOR: John J. Duda, 7922 Wise Ave. Dundalk, Md.
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0227 Registered No. 67 0227

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): REV. WILLIAM DAVID LEIGHTON

2. DATE AND HOUR OF DEATH: 1/5/67 | 8 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: Md GEN HOSP

(If not in hospital or institution, give street address or location): BALTO., Md 21201

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 21217 16 05

D. STREET ADDRESS (If rural, give location): 2520 WEST HARLEM AVE

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	Negro	MARRIED	09/03/99	67				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REV/MINISTER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN LEIGHTON

14. MOTHER'S MAIDEN NAME: ROBINA UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Kenneth R. Koskinen, MD.

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF LUNG. — INTERVAL BETWEEN ONSET AND DEATH: 4 months.

DUE TO

(B) (awaiting biopsy report)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

163X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/31 19 66 to 1/5 19 67, that (I) (we) last saw the deceased alive on 1/5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R. Koskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/5/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: Md GEN HOSPITAL BALTO., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/8/67

24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: R. A. E. Falkenstein

25C. FUNERAL DIRECTOR: Adolphus Halstead

ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BUREAU NO. 67 0228 Registered No. 67 0228

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): James Daniels

2. DATE AND HOUR OF DEATH: 1-3-1967 | 6:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 43 South Baltimore General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 4-02
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21201
D. STREET ADDRESS (If rural, give location): 510 W. Fayette St.

5. SEX: M
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ?
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 62
If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ?
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Lonnie Haywood ADDRESS: 510 W Fayette St

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchopneumonia — day

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

DUE TO
(B) Cerebrovascular Thrombosis — Month
DUE TO
(C) Hypertensive Cardiovascular ds — Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 12-14 1966 to 1-3 1967, that (we) last saw the deceased alive on 1-3 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Rifat Abousy M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-4-1967
23C. PHYSICIAN'S NAME (Type): Rifat Abousy M.D.
23D. ADDRESS: 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/7/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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D-62-0

67 0229

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0229

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MCKINLEY DORSEY

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 12:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2606 Lauretta Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 2606 Lauretta Avenue

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 32
If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Dorsey
14. MOTHER'S MAIDEN NAME: Goldy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-26-4337
17. INFORMANT: Mrs Agnes Dorsey (Wife) ADDRESS:

MEDICAL CERTIFICATION

1B. 581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cirrhosis of liver

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/11/67
23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
23D. LOCATION (City, town, or county) (State): A A County Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
24B. NAME OF REGISTRAR: Robert E. Lindsay M.D.
24C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 151-REV. 1/1/69

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0230 Registered No. 67 0230

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LILYAN L. BURRELL

2. DATE AND HOUR OF DEATH: 1-8-67 2:45 P.M.

CERTIFICATE AMENDED 4-27-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: ANNE ARUNDEL Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ANNAPOLIS 52-10
D. STREET ADDRESS (If rural, give location): 509 OAKLAWN AVE.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	NEGROID	SINGLE	1-10-08	58		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher	A.A. Co. Bd. of Ed.	North Carolina	U.S.A.

13. FATHER'S NAME: ~~ERNEST HARRIS~~ Ernest Burrell

14. MOTHER'S MAIDEN NAME: HATTIE Handy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Dorthy E. Anderson - Darby, Pa. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — 6 hrs

DUE TO

(B) Breast cancer w metastasis — years

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/27 1966 to 1/8 1967, that (I) (we) last saw the deceased alive on 4:45 PM 1/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chu Hsing Tah M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/8/67

23C. PHYSICIAN'S NAME (Type): TAH-Hsiung Hsu M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Cremation	1/12/67	Greenmount	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Faulkner	William Reese, II	Irving, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153 4-27-67 M H

F-432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0231 Registered No. 67 0231

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FLEETWOOD, Burnett Edward

2. DATE AND HOUR OF DEATH: January 8, 1967 11:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Blvd., Baltimore, Maryland 21218

27

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Pennsylvania

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Millersburg

V-35

D. STREET ADDRESS (If rural, give location): R.D.#1, Box 313

5. SEX: Male

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 5/7/17

9. AGE (In years last birthday): 49

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manteince man

10B. KIND OF BUSINESS OR INDUSTRY: Boatyard

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Fleetwood

14. MOTHER'S MAIDEN NAME: Birdie Sheffield

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): 5/9/44 to 11/11/45

16. SOCIAL SECURITY NO.: 219-01-4030

17. INFORMANT: Records ADDRESS: Veterans Administration Hospital, Baltimore, Maryland 21218

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 162.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Undifferentiated Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 4 19 67 to January 8 19 67, that (I) (we) last saw the deceased alive on Jaunary 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.

23A. SIGNATURE: J Habener M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): JOEL HABENER M.D.

23D. ADDRESS: VAH BALTIMORE, MARYLAND 21218

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-11-67

24C. NAME of CEMETERY or CREMATORY: BALTIMORE NATIONAL CEM.

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Jackson

25C. FUNERAL DIRECTOR: WALTERS FUNERAL HOME

ADDRESS: PRATT + STRICKER STS.

VS 150-REV. 1/

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-637

BIRTH NO. 67 0232

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0232

1. NAME OF DECEASED (Type or Print): Bessie Marie Curtis

2. DATE AND HOUR OF DEATH: Jan 6 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 802 Harlem Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17-03

D. STREET ADDRESS (If rural, give location): 802 Harlem Ave

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 10-4-1908

9. AGE (In years last birthday): 58

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James L. Williams

14. MOTHER'S MAIDEN NAME: Sarah R. Smith

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Okedy Sims

ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 1527

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

(B) Carcinoma of Pancreas — 2 mos

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11-21-66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma Pancreas

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-24 1966 to 1-6 1967, that (I) (we) last saw the deceased alive on 1-6-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Franklin Phillips M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): G. Franklin Phillips M.D.

23D. ADDRESS: 558 McMechen St Balto Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Arlington Cem

24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Cloy C. Wilson

ADDRESS: 1011 Brantley Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-315

BIRTH NO. 67 0233

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0233

1. NAME OF DECEASED (Type or Print): WATKINS John

2. DATE AND HOUR OF DEATH: 7 Jan 66 67, 2:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balt.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balt. 15-06
D. STREET ADDRESS (If rural, give location): 3028 W. North Ave.

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W
8. DATE OF BIRTH: 5-22-93
9. AGE (In years last birthday): 72
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ga
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Augustus Watkins
14. MOTHER'S MAIDEN NAME: Mary Richardson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: William A. Watkins
ADDRESS: N. York

MEDICAL CERTIFICATION

18. 450.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Renal failure
DUE TO
(B) Gen - A.S.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bleeding duodenal polyp

19A. DATE OF OPERATION: 1/1/66 12-15-66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bleeding polyp Gangrene of Rt foot
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-13 1966 to 1-7 1967, that (I) (we) last saw the deceased alive on 1-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: T G Dodenhoff M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-7-67
23C. PHYSICIAN'S NAME (Type): T. G. DODENHOFF M.D.
23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Tarbert
25C. FUNERAL DIRECTOR: Roy O Carlson
ADDRESS: Brantly Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

C-540

BIRTH NO. 67 0234

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0234

1. NAME OF DECEASED (Type or Print): MAGGIE MADALINE CONLEY

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 12:20 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02

D. STREET ADDRESS (If rural, give location): 1018 Bennett Place

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: March 7-1898

9. AGE (In years last birthday): 68

If Under 1 Yr. Months | Days | Hours | Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Hawkins

14. MOTHER'S MAIDEN NAME: Frances Dark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Juanita Conley

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-9-67

23C. NAME of CEMETERY or CREMATORY: New Cathedral Cem

23D. LOCATION (City, town, or county) (State): Balto Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Elroy W. Wilson

ADDRESS: 1000 Bramblyn

VS 151-REV. 1/1/65

T-630

BIRTH NO. 67 0235

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0235

1. NAME OF DECEASED (Type or Print): Mary Truitt

2. DATE AND HOUR OF DEATH: January 8, 1967 | 12.05 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kenson

2922 Arunah Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-04

D. STREET ADDRESS (If rural, give location): 64 S. Franklintown Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F.	C.	W.	3/10/94	72				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Virginia	U.S.A.

13. FATHER'S NAME: Bill Boone

14. MOTHER'S MAIDEN NAME: Caroline

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Martha Carr

ADDRESS: 64 S. Franklintown Rd.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 174X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH: Months.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Cardio-vascular Disease — Months

19A. DATE OF OPERATION: NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: ✓

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 23, 1966 to Jan. 8, 1967, that (I) (we) last saw the deceased alive on Jan. 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Frank N. Ogden M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan. 10, 67.

23C. PHYSICIAN'S NAME (Type): FRANK N. OGDEN. M.D.

23D. ADDRESS: 2701 N. Calvert St.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/12/67	Mt. Auburn	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	[illegible]	Charles A. Rice	661 W. Barre St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-30b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0236 Registered No. 67 0236

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Reed, Ella

2. DATE AND HOUR OF DEATH: 1-7-67 11:12 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: 10-01

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE,

D. STREET ADDRESS (If rural, give location): 1238 E. EAGER ST.

5. SEX: FEMALE

6. RACE: NEGROID

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SEPARATED

8. DATE OF BIRTH: 2-7-30

9. AGE (In years last birthday): 36

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOSEPH EVANS

14. MOTHER'S MAIDEN NAME: ALICE HILL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Richard Evans ADDRESS: 1609 N. Milton Ave

MEDICAL CERTIFICATION

1B. 493 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pneumonia

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1-6 1967 to 1-7 1967, that (I) (~~we~~) last saw the deceased alive on 1-7 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David S. Fedson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-7-67

23C. PHYSICIAN'S NAME (Type): DAVID S. FEDSON M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: Mt Calvary

24D. LOCATION (City, town, or county) (State): A. A. County, Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Tarkington

25C. FUNERAL DIRECTOR: Joseph B. Rocks Jr. ADDRESS: 1304 N. Central

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0237 Registered No. 67 0237

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FLORENCE ROBINSON BRUNSON

2. DATE AND HOUR OF DEATH: 1-5-67 | 5 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 UNION MEM. HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 8-04
D. STREET ADDRESS (If rural, give location): 2251 E. Preston St.

5. SEX: F
6. RACE: C.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH:
9. AGE (In years last birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S. C.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MARGARET BELL BANE
ADDRESS: 1114 N. Eden St

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis — immediate
DUE TO
(B) Hypertension — several years
DUE TO
(C) Rheumatic Arthritis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 7/13/62 19 to 1/5/67 19, that (I) (we) last saw the deceased alive on 1/27/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Albert R Laforest M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/8/67
23C. PHYSICIAN'S NAME (Type): DR. ALBERT L. LAFOREST M.D.
23D. ADDRESS: 822 N. Bond St

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/10/67
24C. NAME of CEMETERY or CREMATORY: Mt. CALVARY
24D. LOCATION (City, town, or county) (State): A.A. County, Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Joseph L. Beto Jr.
ADDRESS: 1304 N. Central Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-150 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0238

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0238

1. NAME OF DECEASED (Type or Print): Benjamin F. Chaffin

2. DATE AND HOUR OF DEATH: January 8, 1967 | 6:15p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital, 1514 Division Street, Baltimore, Maryland 21217

39

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 1702

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1229 Division Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): single

8. DATE OF BIRTH: March 3, 1893

9. AGE (In years last birthday): 73

If Under 1 Yr. Months: | Days: | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stocker

10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-3850

17. INFORMANT: Leroy Chaffin-cousin

ADDRESS: 726 Allendale St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

610X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute renal failure

DUE TO

(B) Prostatic hypertrophy

DUE TO

(C) Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 13, 1966 to January 8, 1967, that (I) (we) last saw the deceased alive on January 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: January 9, 1967

23C. PHYSICIAN'S NAME (Type): Dr. C. Laredo M.D.

23D. ADDRESS: 1514 Division Street-Baltimore 17, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 13, 1967

24C. NAME of CEMETERY or CREMATORY: Mt Olive Cem

24D. LOCATION (City, town, or county) (State): Victoria, Virginia

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: [signature]

25C. FUNERAL DIRECTOR: Joseph L. Ruos

ADDRESS: 2222 W. North Ave

VS 150-REV. 1/1/65

M 2541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0239 Registered No. 67 0239

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Vincent John McNeil

2. DATE AND HOUR OF DEATH: 1-9-67 8:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-01

D. STREET ADDRESS (If rural, give location): 321 S. Washington St.

44

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3-27-08

9. AGE (In years last birthday): 58

If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10B. KIND OF BUSINESS OR INDUSTRY: Fireman Tugboat

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: William J McNeil

14. MOTHER'S MAIDEN NAME: Catherine Tyler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): unknown (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 217-14-3501

17. INFORMANT: Catherine McNeil ADDRESS: 321 S. Washington St Baltimore, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 491X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral thrombosis.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-18 1966 to 1-9 1967, that (I) (we) last saw the deceased alive on 1-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R. Vaughn Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type): DR. JOHN R. VAUGHN, JR M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-13-1967

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Lilly & Zeiler Inc. ADDRESS: 1901-07 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M.2-001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0240 Registered No. 67 0240

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MC COY, RUCKER

2. DATE AND HOUR OF DEATH: 1-6-1967 555 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSP. of MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 15-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 2013 CLIFTON AVE.

5. SEX: MALE

6. RACE: COLORED

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 3/ /1901

9. AGE (In years last birthday): 65

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): APPOMADDOX, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES MCCOY

14. MOTHER'S MAIDEN NAME: BERTHA CHAMBERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 225-03-4578

17. INFORMANT: Mr. James L. McCoy ADDRESS: 2013 Clifton Ave.

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 12 days

DUE TO

Acute myocardial infarction — " "

DUE TO

(C) H.A.S.C.V.D. — 4 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-26- 1966 to 1-6- 1967, that (I) (we) last saw the deceased alive on 1-6- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jose R. Sturich M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-6-1967

23C. PHYSICIAN'S NAME (Type): Jose R. STURICH M.D.

23D. ADDRESS: 2519 Gatehouse Dr. BALTO. 7

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Little Zion Cemetery

24D. LOCATION (City, town, or county) (State): Piney River, Virginia

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Morton & Dyett F.H.

ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

GG 36-62-04 1
B.516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0241
M.E. CASE NO.
Registered No. 67 0241

1. NAME OF DECEASED (Type or Print): DORA BUMBREY
2. DATE AND HOUR OF DEATH: 1-8-67 2 20 A.M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore 21224, Maryland
31
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 9-08
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21202
D. STREET ADDRESS (If rural, give location): 922 E. North Avenue

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 8-23-02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Burrell Alford
14. MOTHER'S MAIDEN NAME: Susan Ella Alford
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS: BCH 4940 Eastern Ave. #21224 — ADDRESS

MEDICAL CERTIFICATION

18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebro Vascular Accident — 10 days
DUE TO
(B) Hypertensive Cardio Vascular Disease — many years.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 12-30 1966 to 1-8 1967, that (I) ~~(we)~~ last saw the deceased alive on 1-7 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: James T. Corkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-8-67
23C. PHYSICIAN'S NAME (Type): Dr. James T. Corkins M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-11-67
24C. NAME of CEMETERY or CREMATORY: MT. AUBURN
24D. LOCATION (City, town, or county) (State): Balto. Md.
25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: D Morton + Dyott
ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 67 0242

Registered No. 67 0242

1. NAME OF DECEASED (Type or Print): SARAH B. STARKS

2. DATE AND HOUR OF DEATH: 1-6-67 11:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1942 W. North Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1942 W. North Avenue

5. SEX: F.
6. RACE: N.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: 9-7-1892
9. AGE (In years last birthday): 74
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WINNSBORO, SOUTH CAROLINA U.S.A.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ED BYERS
14. MOTHER'S MAIDEN NAME: MAGGIE BYERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO.
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Lillie Witherspoon
ADDRESS: 1942 W. North

MEDICAL CERTIFICATION

1B. 422.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Carcinoma Vagina Total diverticulosis of colon
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from Dec 27 1957 to Jan 6 1967, that (I) (we) last saw the deceased alive on Jan 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: William H. Watts
M.D.: Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/9/67
23C. PHYSICIAN'S NAME (Type): William H. Watts M.D.
23D. ADDRESS: 5154 Reisterstown Rd. Baltimore Md 21215

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-66
24C. NAME of CEMETERY or CREMATORY: St. Luke Ch. Cem.
24D. LOCATION (City, town, or county) (State): Winnsboro, S.C.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Morton & Dye H.F.H.
ADDRESS: 1701 Laurens

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BIRTH NO. 67 0243

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0243

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Barbara Marie Thurman

2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 9:35 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 142 Cedarmere Rd. Owings Mills MD 21117

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
female	white	Married	Dec. 20, 1931	35	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Automobile Sales	Baltimore, Maryland	USA

13. FATHER'S NAME: James Martin

14. MOTHER'S MAIDEN NAME: Thelma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	--------	212-28-7679	Jimmie Floyd Thurman	142 Cedarmere

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration of blood and internal hemorrhage

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Gunshot wound of chest, involving heart and lungs

~~DUE TO~~

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 142 Cedarmere Rd.

21D. TIME OF INJURY (APPROX.): (Month) 1 (Day) 8 (Year) 67 (Hour) 8:50 p. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Shot in chest with rifle

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/12/67	Baltimore National Cem.	Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Fahey M.D.	Dippel Bro's. Inc	7110 Belair Rd.

VS 151-REV. 1/1/65

N879.4

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M-213

67 0244 BALTIMORE CITY HEALTH DEPARTMENT 67 0244

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MACK McFADDEN

2. DATE AND HOUR PRONOUNCED DEAD: January 8, 1967 12:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2152 Hollins Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-04
D. STREET ADDRESS (If rural, give location): 2152 Hollins Street

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: Ay 22, 1943
9. AGE (In years last birthday): 23
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): S. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest McFadden
14. MOTHER'S MAIDEN NAME: Allien Braveloy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Ernest McFadden
ADDRESS: Same

MEDICAL CERTIFICATION

18. E982X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Stab wound of Chest with Perforation of Heart.
~~DUE TO~~
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Pavement
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Front Pavement of 2152 Hollins Street

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 9 (Year) '67 (Hour) P.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Stabbed during altercation.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-12-67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
23D. LOCATION (City, town, or county) (State): Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
24B. NAME OF REGISTRAR: Robert E. Faber
24C. FUNERAL DIRECTOR: Gray O. Wilson
ADDRESS: 1000 Bentley Ave.

VS 151-REV. 1/1/65

N879.2

T-612

67 0245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0245

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (DAEMON) Mr. Damianos TriPos

2. DATE AND HOUR OF DEATH: January 8, 1967 | 3:40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fayette Nursing Home

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: [redacted]

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Md. 21218 12-03

D. STREET ADDRESS (If rural, give location): 2528 Barclay Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Caucasian	?????	March 15, 1881	85 years		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
???	Restaurant	Greece	Greece

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 204-12-72-98

17. INFORMANT: Mr. Michael Pillires [redacted] ADDRESS: 224 N. Patterson Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
450.01		
(A)	Congestive heart failure	Several months
DUE TO (B)	Generalized arteriosclerosis	Several years
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	None	

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
----	----	No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐	21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 19 19 65 to January 7, 19 67, that (I) (we) last saw the deceased alive on January 7, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. ☐ Med. Director ☑ Staff Phys. ☐

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type): Elmer Ellsworth Cook, Jr., M.D.

23D. ADDRESS: 2431 Maryland Avenue, Baltimore, Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 11, 1967	Prospect Hill Cemetery	Towson, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Hartley, M.D.	Wm. Cook-Brooks, Inc.	1217 St. Paul Street Baltimore, Maryland

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-0001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0246 X Registered No. 67 0246

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNIE M. LEE

2. DATE AND HOUR OF DEATH: 1-5-67 | 1145A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Long Green Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Cockeysville 53-00

D. STREET ADDRESS (If rural, give location): 219 Warren Road

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widowed	May 28, 1876	90		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME: Joshua Shelley

14. MOTHER'S MAIDEN NAME: Rebecca Hackett

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-48-3491-J1

17. INFORMANT: Mrs. Mary Lee Howard ADDRESS: 219 Warren Rd. 21030

MEDICAL CERTIFICATION

18. 491X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronch-pneumonia — 30 hrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 28 1966 to Jan 5 1967, that (I) (~~we~~) last saw the deceased alive on Jany 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. G. Helfrich M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-5-67

23C. PHYSICIAN'S NAME (Type): William G. Helfrich M.D.

23D. ADDRESS: 5006 Roland Ave., Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/9/67	Prospect Hill Cemetery	Towson, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Towson ADDRESS: 1050 York Rd. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

P-635

67 0247

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0247

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DONALD EDWARD PORTMESS

****Donald E. Portmess****Sr.*

2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 10:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-34

D. STREET ADDRESS (If rural, give location): 3909 Frankford Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Jan. 10, 1903

9. AGE (In years last birthday): 63

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker

10B. KIND OF BUSINESS OR INDUSTRY: Airplane Mfg.

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward T. Portmess

14. MOTHER'S MAIDEN NAME: Rena Curry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217-10-6738

17. INFORMANT: Gilbert L. Portmess, ADDRESS: 417 W. 23rd St. Balto.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Jan. 12, 1967

23C. NAME of CEMETERY or CREMATORY: Baltimore Cemetry

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

24B. NAME OF REGISTRAR: Robert E. Fankey M.D.

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.

ADDRESS: 1217 St. Paul St. Baltimore, Maryland

VS 151-REV. 1/1/65

0246

1
H-416

67 0248

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0248

BIRTH NO.

M.E. CASE NO.

Registered No.

1. NAME OF DECEASED (Type or Print): LAWRENCE A. HOLBROOK

2. DATE AND HOUR PRONOUNCED DEAD: January 4, 1967 5:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02

D. STREET ADDRESS (If rural, give location): 6 W. Read Street

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 10/1/05

9. AGE (In years last birthday): 61

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Long Shoreman

10B. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Flordia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 264-18-7701

17. INFORMANT: Joseph Braum ADDRESS: 4218 Hayward Ave. Balto 15, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E 902.9

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Injuries.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 6 W. Read Street 11-02

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 4 (Year) '67 (Hour) P m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Fall from window.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/5/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/9/67

23C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State): Harford Rd. Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Wm. Cook-Brooks FH ADDRESS: 1217 St. Paul St. Balto. Md. 21202

VS 151-REV. 1/1/65

N 8692

A-654

BIRTH NO. 67 0249

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0249

1. NAME OF DECEASED (Type or Print) (MILDRED CARTER ARNOLD) ARNOLD, Mildred C.

2. DATE AND HOUR OF DEATH 1/9/67 3:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

48 MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md. B. COUNTY Balto.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21212 2748

D. STREET ADDRESS (If rural, give location) 600 Cedarcroft Rd.

5. SEX F

6. RACE W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)

8. DATE OF BIRTH 6-11-96.

9. AGE (In years last birthday) 70

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired - sec'y)

10B. KIND OF BUSINESS OR INDUSTRY Lumber Co.

11. BIRTHPLACE (State or foreign country) Md. Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William J. Carter.

14. MOTHER'S MAIDEN NAME Blanche Iola Norwood.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 215 10 5725

17. INFORMANT 1506 Kingsway Road ADDRESS 21218 Pt's chart Mr. Robert B. Carter

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 7514.3 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardiac decompensation

DUE TO Interventrical septal defect ~~Rheumatic valvular disease~~

(B) DUE TO

(C) Co-pulmonale

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 4 1967 to JAN 9 1966, that (I) (we) last saw the deceased alive on JAN 9 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 9 JAN 67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/11/67

24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State) Woodlawn Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 10 1967

25B. NAME OF REGISTRAR [signature]

25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. ADDRESS BALTIMORE MARYLAND

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0250 Registered No. 67 0250

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VIRGINIA JERSCHEID SCHWINGER

2. DATE AND HOUR OF DEATH: JANUARY 7,1967 | 11:15PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 909 McKewin Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218 9-63

D. STREET ADDRESS (If rural, give location): 909 McKewin Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	June 12,1874	92		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore, Maryland	U.S.A.

13. FATHER'S NAME: Michael Jerscheid

14. MOTHER'S MAIDEN NAME: Katherine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Viola V. Mergardt ADDRESS: 909 McKewin Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 1965 to January 7 1967, that (I) (~~we~~) last saw the deceased alive on January 7, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Lloyd E. Saylor M.D. Attending Phys. X Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): Lloyd E. Saylor M.D.

23D. ADDRESS: 3902 Greenmount Avenue

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/11/67	Parkwood Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Fabiano

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS INC. ADDRESS: BALTIMORE MARYLAND 21213

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0251 Registered No. 67 0251

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY REBECCA CALHOUN

2. DATE AND HOUR OF DEATH: Jan. 9. 1967 12:50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2795 ½ The Alameda

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218 9-67

D. STREET ADDRESS (If rural, give location): 2795 ½ The Alameda

5. SEX: Female

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: July 1, 1877

9. AGE (In years last birthday): 89

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Revel Hill, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Noblet

14. MOTHER'S MAIDEN NAME: Hester Miller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Calhoun (Son) ADDRESS: 2795 ½ The Alameda. Baltimore 21218

MEDICAL CERTIFICATION

18. 450.01

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Generalized Arteriosclerosis — Several years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1950 19 to Jan. 19 67, that (I) (~~we~~) last saw the deceased alive on December 26 19 66 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Loy M. Zimmerman M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan. 9 1967

23C. PHYSICIAN'S NAME (Type): LOY M. ZIMMERMAN M.D.

23D. ADDRESS: 3202 Harford Rd. Baltimore 21218

24A. BURIAL CREMATION REMOVAL (Specify): Cremation

24B. DATE: Jan. 10. 1967

24C. NAME of CEMETERY or CREMATORY: Greenmount Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farbman M.D.

25C. FUNERAL DIRECTOR: HENRY SANDER & SONS. INC. ADDRESS: Baltimore Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14-620

BIRTH NO. 67 0252

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67L 0252

1. NAME OF DECEASED (Type or Print): Russell Harris SR. ALEXANDER

2. DATE AND HOUR OF DEATH: 1/7/67 | 11:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL
33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: X
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 408
D. STREET ADDRESS (If rural, give location): 781 WEST MULBERRY STREET 21201

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 2-3-09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Sparrows Point
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FRANK HARRIS
14. MOTHER'S MAIDEN NAME: WINNIE LUCAS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-03-4045
17. INFORMANT: Mrs. Elizabeth A. Harris
ADDRESS: 781 W. Mulberry St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant Metastatic lung tumor
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 12/29 1966 to 1/7 1967, that I (we) last saw the deceased alive on 1/7 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Murray A. Katz M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/8/67
23C. PHYSICIAN'S NAME (Type): MURRAY A. KATZ M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-11-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Marshall Jones, Jr.
ADDRESS: 1735 Harford Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-542

BIRTH NO. 67 0253

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0253

1. NAME OF DECEASED (Type or Print): Lambert Maurice Smelser

2. DATE AND HOUR OF DEATH: January 8, 1967 9 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL 44 BALTIMORE, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson 53-00

D. STREET ADDRESS (If rural, give location): 1201 Merediths Ford Rd.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: April 16, 1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Personnel Work

10B. KIND OF BUSINESS OR INDUSTRY: C+P Telephone Co. Retired

11. BIRTHPLACE (State or foreign country): New Windsor, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Isaac Maurice Smelser

14. MOTHER'S MAIDEN NAME: Frances Elizabeth Lambert

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 577-01-0762

17. INFORMANT: Son - Dr. Rennert Smelser

ADDRESS: 1201 Meredith's Ford Rd - Towson Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

(B) Hypertensive Arteriosclerotic — 18 mos.

DUE TO

Cardio Vascular disease.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

—

19A. DATE OF OPERATION: ○

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from October 1965 to January 1967, that (I) (~~we~~) last saw the deceased alive on December 15 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alfred G. Ossman Jr M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-8-67

23C. PHYSICIAN'S NAME (Type): Alfred G. Ossman Jr M.D.

23D. ADDRESS: 1010 St Paul St Baltimore 2, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-11-67

24C. NAME of CEMETERY or CREMATORY: Emanuel-Baust Lutheran

24D. LOCATION (City, town, or county) (State): Carroll Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0254

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dr Lawrence C. Smyth

2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 11:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 5019 Roland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): 5019 Roland Ave.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2/4/1908
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: Hours: If Under 24 Hrs. Min.:

5-54

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10B. KIND OF BUSINESS OR INDUSTRY: Dentist
11. BIRTHPLACE (State or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry S. Smyth
14. MOTHER'S MAIDEN NAME: Eva M. Houston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: 216-12-8150
17. INFORMANT: Mrs. Deborah S. Terry
ADDRESS: Baltimore, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E 904 D

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Exsanguination
DUE TO
(B) Laceration of scalp
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cirrhosis of liver

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5019 Roland Ave. 27-13

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 8 (Year) 67 (Hour) ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR?: Apparent fall

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/9/67

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/11/1967
23C. NAME of CEMETERY or CREMATORY: Belair Memorial Gardens
23D. LOCATION (City, town, or county) (State): Belair, Harford Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
24B. NAME OF REGISTRAR: Robert E. Fabrey
24C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

0 2 5 3

N 85-8.2

VS 151-REV. 1/1/65

R-341 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0255 Registered No. 67 0255

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Van A. Ridley

2. DATE AND HOUR OF DEATH: 1/4/67 1:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY: 2835 Parkwood Ave #17
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md 13-04
D. STREET ADDRESS (If rural, give location): 2835 Parkwood Ave

5. SEX: MALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 10-28-1901
9. AGE (In years last birthday): 65
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: Ada Ridley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Freddie Mae Ridley Wife
ADDRESS:

MEDICAL CERTIFICATION

18. 151 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) LINNITIS PLASTICA OF STOMACH
DUE TO
(B) METASTASIS TO INTRAABDOMINAL ORGAN
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. UREMIA

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN. 4 1967 to JAN. 4 1967, that (I) (we) last saw the deceased alive on JAN 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/4/67
23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.
23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-8-67
24C. NAME of CEMETERY or CREMATORY: Carver Memorial
24D. LOCATION (City, town, or county) (State): Prince Geo. Co. Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: Rayner Sanders
ADDRESS: 217 E. Preston St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0256

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0256

1. NAME OF DECEASED (Type or Print): Lee, Irma

2. DATE AND HOUR OF DEATH: 1/5/67 | 7:35 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1641 Normal Avenue

8-05

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 3/27/16

9. AGE (In years last birthday): 50

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Matthews DeLaney

14. MOTHER'S MAIDEN NAME: Alma Gibson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Robert Lee

ADDRESS: 1641 Normal Ave

MEDICAL CERTIFICATION

1B. 170X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Ca of breast c metastases

INTERVAL BETWEEN ONSET AND DEATH: > 2 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 1-5 19 67 to 1-5 19 67, that ~~I~~ (we) last saw the deceased alive on 1-5 19 67 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: David S. Fedson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-5-67

23C. PHYSICIAN'S NAME (Type): David S. Fedson M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-67

24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State): A.A. Co. Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

26C. FUNERAL DIRECTOR: Rayner Sanders

ADDRESS: 217 E. Preston St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

32 23 45 1-000

GG 48-45-08

E-663

BIRTH NO. 67 0257

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0257

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): AMELIA EARHART

2. DATE AND HOUR OF DEATH: 1-6-67 | 11 55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 Eastern Avenue, Baltimore 21224, Maryland

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-36

D. STREET ADDRESS (If rural, give location): 4622 O'Donnell Street #21224

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 7-8-86

9. AGE (In years last birthday): 80

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Diedman

14. MOTHER'S MAIDEN NAME: Yengling

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-09-2676A

17. INFORMANT: RECORDS: BCH 4940 Eastern Avenue #21224

ADDRESS:

MEDICAL CERTIFICATION

1B. 433.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) SEPTICEMIA — 18 hours.

DUE TO

(B) FECAL IMPACTION — 1 week.

DUE TO

(C) ARTERIOSCLEROSIS.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ATRIAL FIBRILLATION

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-6 19 67 to 1-6 19 67, that (I) (we) last saw the deceased alive on 1-6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Carlos R. Hamilton M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-7-67

23C. PHYSICIAN'S NAME (Type): Dr. Carlos R. Hamilton M.D.

23D. ADDRESS: Baltimore City Hospitals, 4940 Eastern Ave. #21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Schwarz's

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Helmuth Hoffmann

ADDRESS:

VS 150-REV. 1/1/65

H-22-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0258 Registered No. 67 0258

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cecelia Elizabeth Hajek

2. DATE AND HOUR OF DEATH: Jan 8,1967 8-9. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4729 Pennington Ave

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-05

D. STREET ADDRESS (If rural, give location): 4729 Pennington Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Cau	Married	11/22/1896	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Czeck	

13. FATHER'S NAME: Unk

14. MOTHER'S MAIDEN NAME: Unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No			Family	Same

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute Myocardial Infarction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Apr 57 19 to 1/8/67 19, that (I) (we) last saw the deceased alive on 1/4/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): A. R. Sosnowski M.D.

23D. ADDRESS: 4016 Ritchie Hwy Balto-25. Md

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1/12/67	Holy Cross Cem	A A Co	Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 10 1967	Robert E. Falkenhan	McCully F H	237 Patapsco Ave 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-52

BIRTH NO. 67-00438 67 0259

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0259

1. NAME OF DECEASED (Type or Print): Baby Girl Thomas

2. DATE AND HOUR OF DEATH: 1/8/67 6:20 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 7-04

D. STREET ADDRESS (If rural, give location): 1016 N. WOLFE ST.

5. SEX: F

6. RACE: N

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NM

8. DATE OF BIRTH: 1/3/67

9. AGE (In years last birthday):

If Under 1 Yr. Months: Days: 4 Hours: 8 If Under 24 Hrs. Min.: 47

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: DOROTHY HARRISON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 768.5 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Prematurity E

DUE TO

(B) Prolonged Rupture of

DUE TO

(C) Membranes (Probable Sepsis)

INTERVAL BETWEEN ONSET AND DEATH: 4 days 8 47/60 hrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3 1967 to 1/8 1967, that (I) (we) last saw the deceased alive on 1/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard D. Bland M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/8/67

23C. PHYSICIAN'S NAME (Type): RICHARD D. BLAND M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): CREMATION

24B. DATE: 1-9-67

24C. NAME of CEMETERY or CREMATORY: JOHNS HOPKINS HOSPITAL

24D. LOCATION (City, town, or county) (State): BALTIMORE, MD 21205

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Fankuna

25C. FUNERAL DIRECTOR: 0 2 HOSPITAL DISPOSAL

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-53

BIRTH NO. 67 0260 Mc Connellsburg, Pa.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0260

1. NAME OF DECEASED (Type or Print): LANDERS, DANIEL

2. DATE AND HOUR OF DEATH: 1-6-67 | 8 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Wash. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): HANCOCK 71-00

D. STREET ADDRESS (If rural, give location): Rt 1

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NM

8. DATE OF BIRTH: 10-13-66

9. AGE (In years last birthday): 3 mos

If Under 1 Yr. Months: 2 Days: 23 | If Under 24 Hrs. Hours: | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mc Connellsburg, Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald B. Landers

14. MOTHER'S MAIDEN NAME: Janice

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: DONALD B. LANDERS

ADDRESS: RFD #1, HANCOCK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Congenital Anomalies

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

759.31

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-5-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: INGUINAL HERNIAS

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/9 1966 to 1/6 1967, that (I) (we) last saw the deceased alive on 1/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: M. J. Adams M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-6-67

23C. PHYSICIAN'S NAME (Type): M. J. ADAMS M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/8/67

24C. NAME of CEMETERY or CREMATORY: MT. OLIVET PRESBY. CEME.

24D. LOCATION (City, town, or county) (State): RURAL HANCOCK WASH., MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Howard F. Grove

ADDRESS: Hancock Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-622

BIRTH NO. 67 0261

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0261

1. NAME OF DECEASED (Type or Print): DIERKES, JOSEPH A

2. DATE AND HOUR OF DEATH: JANUARY 6, 1967 8:45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: 21227 Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 5605 OREGON AVENUE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 12-08-78

9. AGE (In years last birthday): 88

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUGUST Dierkes DEC'D

14. MOTHER'S MAIDEN NAME: MARY DEC'D

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-14-0845

17. INFORMANT: HOSPITAL SLIP-ST. AGNES HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B) Anemia due to

DUE TO

(C) Ca of prostate c bladder & lymphoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JANUARY 2, 1967 to JANUARY 6, 1967, that (I) (we) last saw the deceased alive on JANUARY 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George S. Patrick M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/06/67

23C. PHYSICIAN'S NAME (Type): GEORGE S. PATRICK M.D.

23D. ADDRESS: AVE.S, BALTO., MD. 21229 ST. AGNES HOSPITAL-CATON AND WILKENS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G 1-63 1 6

BIRTH NO. 67 0262

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0262

1. NAME OF DECEASED (Type or Print): MAMIE C. GARTRELL

2. DATE AND HOUR OF DEATH: January 6, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1327 James Street, Baltimore, Maryland

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-02

D. STREET ADDRESS (If rural, give location): 1327 James Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12-23-1893

9. AGE (In years last birthday): 73

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John J. Barry

14. MOTHER'S MAIDEN NAME: Maggie Cavanaugh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Michael F. Barry, 951 Circle Drive

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 199.2 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Bronchopneumonia — 2 days

DUE TO

(B) malnutrition — 3 weeks

DUE TO

(C) Carcinoma, adeno — 25 yrs ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Dec 1966

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: bowel obstruction

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Jan 1947 19 to Jan 1967, that (I) (~~we~~) last saw the deceased alive on Jan 5, 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: H H Baylus M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 7 Jan 67

23C. PHYSICIAN'S NAME (Type): Dr. Herman H. Baylus M.D.

23D. ADDRESS: 1600 Wilkens Avenue, Balto., Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-1967

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: Robert E. Kelly, M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-52-b

BIRTH NO. 67 0263

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0263

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Hammock, Richard

2. DATE AND HOUR OF DEATH: January 6th, 1967 | 11:50 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Agnes Hospital
40 Caton & Wilkens Aves. 21229

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-31
D. STREET ADDRESS (If rural, give location): 4610 Ridge Ave. 2127

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7/2/1899
9. AGE (In years last birthday): 67
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aaron Hammock
14. MOTHER'S MAIDEN NAME: Fannie Wilson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 216-18-0099
17. INFORMANT: Mrs. Mary L. Hammock, ADDRESS: 4610 Ridge Ave. 21227

MEDICAL CERTIFICATION

1B. 451X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) hemo thorax
DUE TO
(B) ruptured thoracic aortic aneurysm
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Jaime V. del Pilar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/6/67
23C. PHYSICIAN'S NAME (Type): Jaime V. Del Pilar M.D.
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-9-1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967
25B. NAME OF REGISTRAR: Robert E. Talley, M.D.
25C. FUNERAL DIRECTOR: Howard H. Hubbard, ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

42-02-45 DH K-350

BIRTH NO. 67 0264

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0264

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Erie Brown Keaton

2. DATE AND HOUR OF DEATH: 1/9/67 1 50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION: Balto City Hosp (If not in hospital or institution, give street address or location) 4940 Eastern Avenue Baltimore, Maryland #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-02
D. STREET ADDRESS (If rural, give location): 2336 Lauretta Ave. #21223

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: 6/5/11
9. AGE (In years last birthday): 55 — If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): cook?
10B. KIND OF BUSINESS OR INDUSTRY: ?
11. BIRTHPLACE (State or foreign country): Florida ~~Md~~
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: BCH RECORDS Chart — ADDRESS: 4940 Eastern Avenue Baltimore, Maryland #21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatic coma
DUE TO
(B) Cirrhosis
DUE TO
(C) Chronic alcoholism

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/2 1966 to 1/9 1967, that (I) (we) last saw the deceased alive on 1/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. T. Davidson M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/9/67
23C. PHYSICIAN'S NAME (Type): J. T. Davidson M.D.
23D. ADDRESS: BCH 4940 Eastern Avenue Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-67
24C. NAME of CEMETERY or CREMATORY: Carver Mem. PK.
24D. LOCATION (City, town, or county) (State): A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Jackson
25C. FUNERAL DIRECTOR: Solomon Funeral Home 1011-13 N. Arlington Ave — ADDRESS

VS 150-REV. 1/1/65

B-560

67 0265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0265

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Buchner Eda

2. DATE AND HOUR OF DEATH: 1/9/67 | 1 40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 House in Pines - Belair 5837 Belair Rd. #6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: 15-10

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21215

D. STREET ADDRESS (If rural, give location): 4101 Belvieu Ave

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married

8. DATE OF BIRTH: Nov. 11, 1882

9. AGE (In years last birthday): 84

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Otto Buchner

14. MOTHER'S MAIDEN NAME: Dora Gude

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Eda Buchner

ADDRESS: 4101 Belvieu Ave Baltimore Md

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic Heart Disease — yrs.

DUE TO

(B) Generalized Arteriosclerosis — yrs.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Brain Syndrome — yrs.

Decubitus when confined — 2 months.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 1959 to January 9 1967, that (I) (we) last saw the deceased alive on Jan. 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did~~not~~) view the body after death.

23A. SIGNATURE: Albert B. Bradley M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): M.D.

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Fabian

25C. FUNERAL DIRECTOR: Harry N. Armacost

ADDRESS: 1209 Ridgewood Ave Balto Md 21215

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-230

67 0266

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 0266

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PETER CIEKOT

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 9:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Church Homes & Hospital (DOA)

35/99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-02
D. STREET ADDRESS (If rural, give location): 613 S. Kenwood Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: JUNE 30 1922
9. AGE (In years last birthday): 48
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY: A. C. C.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: GEORGE CIEKOT
14. MOTHER'S MAIDEN NAME: JOSEPHINE SABA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 218-07-1447
17. INFORMANT: MRS. ANETTA CIEKOT
ADDRESS: 613 S. KENWOOD AVE

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous pleuritis with cardiac amyloidosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Arteriosclerotic heart disease

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: JAN. 10, 1967
23C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cem.
23D. LOCATION (City, town, or county) (State): BALTIMORE MD.

24A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Raymond J. Kaczorowski
ADDRESS: 2525 FLEET ST.

VS 151-REV. 1/1/65

M-32-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0267 Registered No. 67 0267

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Matthews, Robert J.

2. DATE AND HOUR OF DEATH: 1/8/67 6 13 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital of Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-44 D. STREET ADDRESS (If rural, give location): 4318 Baltimore St.

5. SEX: M. 6. RACE: Caus. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: 4/29/15 9. AGE (In years last birthday): 51 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Baltimore 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jeremiah Matthews 14. MOTHER'S MAIDEN NAME: Charlotte Price

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 215-07-5968 17. INFORMANT: Mrs. Pearl G. Matthews, 4318 Baltimore St. ADDRESS 21227

MEDICAL CERTIFICATION

1B. 153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Tracheal occlusion — 3 weeks

DUE TO

(B) Metastatic Carcinoma of Colon — 2 years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/4/67 1967 to 1/8 1967, that (I) (we) last saw the deceased alive on 1/8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Erwin H. Hesselberg M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑ 23B. DATE SIGNED: 1/8/67

23C. PHYSICIAN'S NAME (Type): Erwin H. Hesselberg M.D. 23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1-11-1967 24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery 24D. LOCATION (City, town, or county) (State): Anne Arundel County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967 25B. NAME OF REGISTRAR: Robert E. Fakyma 25C. FUNERAL DIRECTOR: Howard H. Hubbard ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-4/6

BIRTH NO. 67 0268

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0268

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): ALBERT, MILTON

2. DATE AND HOUR OF DEATH: 1/7/67 11:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP OF BALT

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALT
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-20
D. STREET ADDRESS (If rural, give location): 4004 ROSECREST AVE

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 11/19/02
9. AGE (In years lost birthday): 64
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel Albert
14. MOTHER'S MAIDEN NAME: Rachel Kaufman
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-05-7283
17. INFORMANT: Mrs Augusta Albert — ADDRESS: 4004 Rosecrest Ave

MEDICAL CERTIFICATION

1B. 420.1 260X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) MYOCARDIAL INFARCTION — 1 DAY

DUE TO

(B) ASHD — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: DIABETES

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7 1967 to 1/7 1967, that (I) (we) last saw the deceased alive on 1/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/7/67
23C. PHYSICIAN'S NAME (Type): D. A. SPOTT M.D.
23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 8/67
24C. NAME of CEMETERY or CREMATORY: Arche Emunah
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Tarkington
25C. FUNERAL DIRECTOR: Sol Levinson & Bros Inc
ADDRESS: 6010 Reisterstown Road

VS 150-REV. 1/1/65

H-632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0269 Registered No. 67 0269

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Hurwitz, Anna, F.

2. DATE AND HOUR OF DEATH: 1/6/67 8 25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4516 Garden Drive

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 68
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Moses Feinberg
14. MOTHER'S MAIDEN NAME: Pearl?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 145-07-0384
17. INFORMANT: Mr Paul Lattel — ADDRESS: 3302 Essex Rd

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction DUE TO

(B) Arteriosclerotic Cardiovascular disease DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 1966 to Jan 1967, that (I) (we) last saw the deceased alive on 1/4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harvey S. Feuerman M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/6/67
23C. PHYSICIAN'S NAME (Type): Harvey S. Feuerman M.D.
23D. ADDRESS: 6210 Park Heights Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 8/67
24C. NAME of CEMETERY or CREMATORY: Chevrah Amuno
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Tarling
25C. FUNERAL DIRECTOR: Sol Levinson & Bros Inc — ADDRESS: 6010 Reisterstown Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0270 Registered No. 67 0270

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WALTER P. SENKEWIC

2. DATE AND HOUR OF DEATH: 1/9/1967 | 3:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 21-01
D. STREET ADDRESS (If rural, give location): 901 W. Barre St - 21230

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	WHITE	widowed	1 MAY 1885	81				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist	Railroad	Lithuania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	—	—	Walter T. Senkewic	905 W. Barre St. (30)

MEDICAL CERTIFICATION

18. 24 / X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) Coronary Occlusion	1 DAY
DUE TO Arteriosclerosis - Coronary	12 YEARS
(B) Bronchial Asthma	20 YEARS
DUE TO Arteriosclerotic Cardio-Vascular Disease	12 YEARS
(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — —

19A. DATE OF OPERATION: NONE | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20A. AUTOPSY? (Yes or No): NO | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ | 21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (~~this hospital~~) attended the deceased from 12 Jan 1947 to 9 January 1967, that (I) (~~we~~) last saw the deceased alive on 9 January 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Edward F. Milan M.D. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ | 23B. DATE SIGNED: 10 January 1967

23C. PHYSICIAN'S NAME (Type): EDWARD F. MILAN, M.D. M.D. | 23D. ADDRESS: 682 WASHINGTON BLVD BALTO, MD 21230

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/13/67	Holy Cross Cemetery	Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 11 1967	R. C. & E. F. Fahrney	John J. Howard & Son Inc.	901 Hollins St. Balto Md. 21223

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0271 Registered No. 67 0271

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EMMA A. CERMAK

2. DATE AND HOUR OF DEATH: JANUARY 9, 1967 | 10:00 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL 36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 25-05
D. STREET ADDRESS (If rural, give location): 4801 PENNINGTON AVE. 26

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7/26/00
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-326-324
17. INFORMANT: PATIENTS CHART
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

450.1

(A) Generalized Arteriosclerosis — years

DUE TO

(B) Gangrene, legs, bilateral — 3 mos

DUE TO

(C) Toxemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/11 19 66 to 1/9 19 67, that (I) (we) last saw the deceased alive on 10:00 PM, 1/9 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ferdinand C. Rodriguez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: JAN. 9, 1967

23C. PHYSICIAN'S NAME (Type): FERDINAND C. RODRIGUEZ M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Holy Cross Cem
24D. LOCATION (City, town, or county): A A Co (State): Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Fairbairn
25C. FUNERAL DIRECTOR: McCully F H 237 Patapsco Ave
ADDRESS: 21225

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-43-28 DH

F 2460

BIRTH NO. 67 0272

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0272

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): FOWLER, HARRY E

2. DATE AND HOUR OF DEATH: 6 Jan. 67 | 8:20 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Avenue, Baltimore, Maryland #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ESSEX 53-00

D. STREET ADDRESS (If rural, give location): 616 Virginia Avenue #21221

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7-15-03

9. AGE (In years last birthday): 63

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Fowler - Deceased

14. MOTHER'S MAIDEN NAME: Sadie Williams - Deceased

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-8191

17. INFORMANT: RECORDS: BCH ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland #21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	Cause	Interval between onset and death
(A)	Massive GI Hemorrhage	? 6 m.
DUE TO (B)	Stress ulcer	2 da
DUE TO (C)	Cardiac & Resp arrest, Resuscitated	3 da
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Massive Anasarca, ?20° to MF	2 wks

19A. DATE OF OPERATION: 1-5-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Respiratory Insufficiency

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): no

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-4-67 19 to 1-6-67 19, that (I) (we) last saw the deceased alive on 1-6-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. W. Douglas, III M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-6-67

23C. PHYSICIAN'S NAME (Type): S. W. Douglas, III M.D.

23D. ADDRESS: 4940 Eastern Avenue, Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/9/67

24C. NAME of CEMETERY or CREMATORY: Garden of Faith

24D. LOCATION (City, town, or county) (State): Balto. Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Fairman

25C. FUNERAL DIRECTOR: J. E. Connelly Sons ADDRESS: 300 Moore

VS 150-REV. 1/1/65

W-36 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0273

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0273

1. NAME OF DECEASED (Type or Print): MARGUERITE WEATHERSBEE

2. DATE AND HOUR OF DEATH: JAN 7 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 ARDLEIGH NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALTO Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ESSEX 53-00
D. STREET ADDRESS (If rural, give location): 902 ASHBRIDGE DR.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW
8. DATE OF BIRTH: OCT. 7, 1887
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LUTHER KING
14. MOTHER'S MAIDEN NAME: LENA MALLORY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 240-32-7771
17. INFORMANT: WM. A. WEATHERSBEE
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — 6 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to Jan. 1967, that (I) (we) last saw the deceased alive on 2 Jan. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Morris Rainess M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-7-67
23C. PHYSICIAN'S NAME (Type): MORRIS RAINESS M.D.
23D. ADDRESS: 1105 Old Eastern Ave. Essex, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE:
24C. NAME of CEMETERY or CREMATORY: PINEVIEW
24D. LOCATION (City, town, or county) (State): ROCKY MOUNT N.C.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: J.G. CONNELLY SONS
ADDRESS: 300 MACE

VS 150-REV. 1/67

(2) B-650

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0274 Registered No. 67 0274

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Karen Brown

2. DATE AND HOUR OF DEATH: Jan 8 1967 7 00 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 JOHNS HOPKINS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTO. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 116 KINGSTON ROAD

5. SEX: FEMALE
6. RACE: CAU
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 12-4-49
9. AGE (In years last birthday): 17
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT BROWN
14. MOTHER'S MAIDEN NAME: LORETTA KREPPS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ROBERT BROWN ADDRESS: 116 KINGSTON RD

MEDICAL CERTIFICATION

18. 456X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Renal failure — 1 year
DUE TO
(B) Malignant hypertension — 1 year
~~DUE TO~~
AND
(C) systemic lupus erythematosis — 9 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

19A. DATE OF OPERATION: None
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from Jan 7 1967 to Jan 8 1967, that (I) (we) last saw the deceased alive on Jan 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [illegible] M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Jan 8/ 1967
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/67
24C. NAME of CEMETERY or CREMATORY: Holly Hill
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Farbman
25C. FUNERAL DIRECTOR: J. Fr. Connolly Sons ADDRESS: 300 Mace

VS 150-REV. 1/1/65

W-435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0275 Registered No. 67 0275

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ESTHER ELLEN WALTMAN

2. DATE AND HOUR OF DEATH: JAN 7, 1967 10 45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL BALTIMORE 1, MD.

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: ANNE ARUNDEL Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GLEN BURNIE 52-00

D. STREET ADDRESS (If rural, give location): 205 ST. JAMES PLACE

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 10/27/23

9. AGE (In years last birthday): 43

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN EDWARD EWING

14. MOTHER'S MAIDEN NAME: GRACE ELLEN ALFORD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: DONALD J. WALTMAN ADDRESS: SAME AS A.C.D.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. 433.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) THIRD DEGREE HEART BLOCK — 6-7 YRS

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: EXCEPT CATHETER PACEMAKER

20A. AUTOPSY? (Yes or No): PARTIAL

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7/67 19 to 1/7/67 19, that (I) (we) last saw the deceased alive on 1/7/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert T. Singleton M.D. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): ROBERT T. SINGLETON M.D.

23D. ADDRESS: 5109 BROOK GREEN RD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: Meadowridge Memorial Pk.

24D. LOCATION (City, town, or county) (State): Howard Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Robert Pearce Singleton Funeral Home

ADDRESS: Glen Burnie

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 0276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0276

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RICKARD, JOSEPHINE TYSON

2. DATE AND HOUR OF DEATH: 1/7/67 1:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: A.A.Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Pasadena 52-00

D. STREET ADDRESS (If rural, give location): Anne Arundel County

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8/17/09

9. AGE (In years last birthday): 57

If Under 1 Y.: Months Days

If Under 24 Hrs.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: NA

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Husband ADDRESS:

MEDICAL CERTIFICATION

18. 332X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis, Generalized — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B) Bilateral Nuclear Cataract — 1 month

DUE TO

(C) Arty Occlusion.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NA

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: NA

20A. AUTOPSY? (Yes or No): No.

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): NA

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? NA

22. I certify that (I) (this hospital) attended the deceased from 12/14/66 19 to 1/7 19 67, that (I) (we) last saw the deceased alive on 1/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Bernard S. Karpers M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/7/67

23C. PHYSICIAN'S NAME (Type): BERNARD S. KARPERS M.D.

23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State): Brooklyn R.F.D. Md.

25A. DATE RECEIVED BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Alice B. Tarbert M.D.

25C. FUNERAL DIRECTOR: Robert Pearce Singleton Funeral Home / Glen Burnie, Md. ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-62b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0277 Registered No. 67 0277

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Harris Mrs. Louise MARY

2. DATE AND HOUR OF DEATH: Jan. 9. 1967 | 10:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If rural, give location): 6911 Fifth Avenue

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 8/25/06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Napora
14. MOTHER'S MAIDEN NAME: MARY Z SOBUS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 213-03-8433
17. INFORMANT: WILLIAM J. HARRIS ADDRESS: 6911 Fifth ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 151X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach
DUE TO Advanced Stage

ANTECEDENT CAUSES

(B)
DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from Jan 9 4:00 pm 19 67 to Jan 9 (10:20 pm) 19 67, that (we) last saw the deceased alive on Jan 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (view the body after death.

23A. SIGNATURE: Milagros L. Guerrero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: Jan. 9, 1967
23C. PHYSICIAN'S NAME (Type): MILAGROS L. GUERRERO M.D.
23D. ADDRESS: BON Secours Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/13/67
24C. NAME of CEMETERY or CREMATORY: ST. STANISLAUS
24D. LOCATION (City, town, or county) (State): BALTIMORE, Md

25A. DATE RECEIVED BY HEALTH DEPT. JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Fulton
25C. FUNERAL DIRECTOR: George G. Weber ADDRESS: 745 S. ANN ST

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-55d

BIRTH NO. 67 0278

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0278

1. NAME OF DECEASED (Type or Print): Emil Neuman

2. DATE AND HOUR OF DEATH: January 9th. 1967 8 00 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4251 Nicholas Ave. 6

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: 4251 Nicholas Ave. B. COUNTY: 6

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md. 26-02

D. STREET ADDRESS (If rural, give location): 4251 Nicholas Ave. 6

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Oct. 29, 1900

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Emil Neuman

14. MOTHER'S MAIDEN NAME: Mary Blaha

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): ----

(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: 212-05-6310

17. INFORMANT: Mrs. Sadie E. Neuman, 4251 Nicholas Ave. 6

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO: A SCVD — 5 years

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1965 to 1/9 1967, that (I) (we) last saw the deceased alive on 1/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George H. Beck M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/11/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: 6012 Belford Rd, Balto, Md 21214

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 13/67

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith

24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Fairman

25C. FUNERAL DIRECTOR: Philip Herwig Sons

ADDRESS: 2024 Orleans St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0279 Registered No. 67 0279

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH D RAINER

2. DATE AND HOUR OF DEATH: 1/10/67 12:40 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME + HOSP.

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 601

D. STREET ADDRESS (If rural, give location): 411 N. STREEPER ST (24)

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 2/2/92

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman (Retired)

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Fire Dept.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHARLES RAINER

14. MOTHER'S MAIDEN NAME: MARY KAUSE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no

(If yes, give war or dates of service): ---------

16. SOCIAL SECURITY NO.: 216-32-9634

17. INFORMANT: Estelle M. Baumgartner ADDRESS: 2475 Fairway

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction — Days

DUE TO

(B) Arteriosclerotic cardio — Years

DUE TO vascular disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ✓

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to 1/10 19 67, that (I) (we) last saw the deceased alive on 1/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Francisco Baltazar Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR, JR. M.D.

23D. ADDRESS: Church Home + Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/13/67

24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county): Baltimore (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: [illegible] E. Fa[illegible] M.D.

25C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Baltimore St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0280 Registered No. 67 0280

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Whitehill, Mary

2. DATE AND HOUR OF DEATH: 1/9/67 1 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Charles General Hospital 2714 N. Chas. St. 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21214-27-06
D. STREET ADDRESS (If rural, give location): 2304 Echodale Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
Female	Wh.	widowed	12/19/90	76 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hawkins, Martin

14. MOTHER'S MAIDEN NAME: Feehley, Ella

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-07-8424-A

17. INFORMANT: chart ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 + 1 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypertensive Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus; long-standing

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-8 1967 to 1-8 1967, that (I) (we) last saw the deceased alive on 1-8 Am 1-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Angelita A. Toppino M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type): ANGELITA A. TOPPINO M.D.

23D. ADDRESS: NC 2H. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/12/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county): Baltimore (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: John A. Moran, Inc. ADDRESS: 3000 E. Balto. St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
0-625

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0281 Registered No. 67 0281

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Pablo Organ

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 | 8:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 1610 Shakespeare St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-03
D. STREET ADDRESS (If rural, give location): 1610 Shakespeare St.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: Dec. 25,1901
9. AGE (In years last birthday): 65 ~~yrs~~
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Stand. Radiator
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: John Organ
14. MOTHER'S MAIDEN NAME: Barbara Qualek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: 103-22-4131
17. INFORMANT: Joseph F. Organ
ADDRESS: 500 S. Macon St. Balto., 21224, Md.

MEDICAL CERTIFICATION

18. 4221 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Arteriosclerotic cardiovascular disease
(A)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary emphysema

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-11-67.
23C. NAME of CEMETERY or CREMATORY: Mt. Carmel Cemetery
23D. LOCATION (City, town, or county) (State): 5712 O'Donnell St. Balto., 24, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
24B. NAME OF REGISTRAR: Robert E. Farley, M.D.
24C. FUNERAL DIRECTOR: Charles S. Geiler
ADDRESS: 901 S. Conkling St Balto., 21224, Md.

VS 151-REV. 1/1/65

B-424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0282 Registered No. 67 0282

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Reginald Blackwell (F) BLACKWELL

2. DATE AND HOUR OF DEATH: 1/9/67 4 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital 3B

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 138-06
D. STREET ADDRESS (If rural give location): 1825 - E. Lafayette Ave

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro.	Married.	11-24-97	69.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Kill Fireman	General Refast.	Goldvein, Va.	U.S.A.

13. FATHER'S NAME: David Blackwell

14. MOTHER'S MAIDEN NAME: ~~Ethel Madeu~~ Katie Carpenter

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Clarence Blackwell ADDRESS: Same

MEDICAL CERTIFICATION

18. 592X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Uremia
DUE TO
(B) Chronic Renal Disease
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 12/6 1966 to 1/9 1967, that ~~I~~ (we) last saw the deceased alive on 1/9 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: M. Katz M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): M. KATZ M.D.

23D. ADDRESS: J. HH

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-13-67	Carver Mem Park	Laurel	Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 11 1967	Robert E. Falkenau	Elroy O. Wilson	1000 Brantley Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-340

BIRTH NO. 67 0283

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0283

1. NAME OF DECEASED (Type or Print): OETTEL, MAX HANS

2. DATE AND HOUR OF DEATH: 9th JANUARY 1967 4.45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSP. BALTIMORE

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2734

D. STREET ADDRESS (If rural, give location): 6116 BELAIR ROAD

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 02-08-1895

9. AGE (In years last birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PATROLMAN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: OETTEL

14. MOTHER'S MAIDEN NAME: MARIE ? SHOUMAN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Elizabeth Fadl

ADDRESS: 5939 Park Rd Balto Md

MEDICAL CERTIFICATION

18. 600.0 I 0081

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) CHRONIC PYELONEPHRITIS WITH UREMIA

DUE TO

(B)

DUE TO

(C) CONGESTIVE HEART FAILURE

INTERVAL BETWEEN ONSET AND DEATH: OVER 1 YEAR

1 YEAR

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DIABETES MELLITUS

OLD TUBERCULOSIS

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-9 3.15 AM 1967 to 1-9 4.45 PM 1967, that (I) (we) last saw the deceased alive on 1-9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridjofur Bjornsson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-9 1967

23C. PHYSICIAN'S NAME (Print): FRIDJOFUR BJORNSSON

FRIDJOFUR BJORNSSON M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL

THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-12-67

24C. NAME of CEMETERY or CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Northdale Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Falkins

25C. FUNERAL DIRECTOR: Hall Bros.

ADDRESS: 7210 Harford Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-221

67 0284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0284

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPHINE RAKOWSKI

2. DATE AND HOUR OF DEATH: JAN. 7, 1967 | 1 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 216 S. PATTERSON PK. AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1-05

D. STREET ADDRESS (If rural, give location): 216 S. PATTERSON PARK AVE.

00

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 3-19-1896

9. AGE (In years last birthday): 70 71

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): POLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: STANLEY KORDECKI

14. MOTHER'S MAIDEN NAME: MARYANNA CHOROMANSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: JOSEPH KOWALSKI

ADDRESS: 216 S. PATTERSON PK AVE

MEDICAL CERTIFICATION

18. 450.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1956 to 1/7 1967, that (I) (~~we~~) last saw the deceased alive on 12/30 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Sheldon C. Kranitz M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS: M.D. 6715 Park Hts. Ave. 15

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-10-67

24C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEM.

24D. LOCATION (City, town, or county) (State): BALTO, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: JOHN M. WEBER & SONS INC

ADDRESS: 401 S. CHESTER ST.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1 W-1480

BIRTH NO. 67 0285

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0285

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Ossie E. Weller

2. DATE AND HOUR OF DEATH: Jan. 10, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gen. German Aged Home, 22 S. Athol Ave.

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 28-001
D. STREET ADDRESS (If rural, give location): 22 S. Athol Ave.

5. SEX: F
6. RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10-1-84
9. AGE (In years last birthday): 82
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - Abraham Caybor
14. MOTHER'S MAIDEN NAME: Late - Frances ----

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Gen. German Aged Home, 22 S. Athol Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arteriosclerosis
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C) Arteriosclerotic Myocardial Degeneration & failure

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1965 to Jan 1967, that (I) (we) last saw the deceased alive on Jan 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William J. Bryson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 10 Jan 67
23C. PHYSICIAN'S NAME (Type): William J. Bryson M.D.
23D. ADDRESS: 4605 Edmondson Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-67
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Fairman
25C. FUNERAL DIRECTOR: Witzke F.D. ADDRESS: 4101 Edmondson Ave.

VS 150-REV. 1/1/65

B/ H-1630

BIRTH NO. 67 0286

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0286

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): LULA M. HARDY

2. DATE AND HOUR OF DEATH: 1-10-1967, 2:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 505 GLEN ALLEN DR. APT. 28-04

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 11-10-79
9. AGE (In years last birthday): 87
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): TENN.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Williams
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 410-05-1604
17. INFORMANT: Miss Idella Hardy
ADDRESS: 505 Glen Allen Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction
DUE TO
(B) Hypertensive congestive heart failure
DUE TO
(C) Pneumonia

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (this hospital) attended the deceased from 1-5 1967 to 1-10 1967, that (I) (we) last saw the deceased alive on 1-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lucas C. Vidhyaphum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-10-67
23C. PHYSICIAN'S NAME (Type): LUCAS C. VIDHYAPHUM M.D.
23D. ADDRESS: Lutheran Hospital of Maryland.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: EAST VIEW
24D. LOCATION (City, town, or county) (State): UNION City, TENN.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Wolfe F.P.
ADDRESS: 4101 Edmondson Ave

VS 150-REV. 1/1/65

BIRTH NO. 67 0287

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0287

1. NAME OF DECEASED (Type or Print): Miss Grace E. Hammett

2. DATE AND HOUR OF DEATH: 10 JAN 67 | 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN'L HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTO. CITY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE. 1202
D. STREET ADDRESS (If rural, give location): 3501 St. Paul St.

48

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	NEVER MARRIED	9/30/89	77				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Bd. of Ed.

11. BIRTHPLACE (State or foreign country): BALTO., MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Hammett

14. MOTHER'S MAIDEN NAME: Spangler

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-40-7334

17. INFORMANT: Mr. Edw. C. O'Dell 3902 Greenway

MEDICAL CERTIFICATION

18. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arterio sclerotic Cardiovasc. Disease — ?

DUE TO

(B) Cerebral Vasc. Hemorrhage — 5 JAN 67

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5 JAN 1967 to 10 JAN 1967, that (I) (we) last saw the deceased alive on 10 JAN 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dean H. Griffin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 10 JAN 67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-12-67

24C. NAME of CEMETERY or CREMATORY: Mt. Olivet Cem.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Witzke F.D. — ADDRESS: 4101 Edmondson Av.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D 622

BIRTH NO. 67 0288

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0288

1. NAME OF DECEASED (Type or Print): Catherine B. Dorsey

2. DATE AND HOUR OF DEATH: January 8, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gen. German Aged Home 22 S. Athol Ave.

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Gen. German Aged Home-22 S. Athol Ave.

28-04

5. SEX: F
6. RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3-2276
9. AGE (In years last birthday): 90
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - Peter J. Little
14. MOTHER'S MAIDEN NAME: Late - Hausen

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Gen. German Aged Home
ADDRESS: 22 S. Athol Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebral Thrombosis
DUE TO
(B) Cerebral arteriosclerosis
DUE TO
(C) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1963 to 8 Jan 1967, that (I) (we) last saw the deceased alive on 8 Jan 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William J. Bryson M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 9 Jan 67
23C. PHYSICIAN'S NAME (Type): William J. Bryson M.D.
23D. ADDRESS: 4605 Edmondson Ave.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-67
24C. NAME OF CEMETERY or CREMATORY: Greenmount Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Witzke F. D. 4101 Edmondson Ave.
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

G-320

BIRTH NO. 67 0289

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0289 Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Cornell Godsey

2. DATE AND HOUR PRONOUNCED DEAD: 1/10/67 9:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03
D. STREET ADDRESS (If rural, give location): 2407 E. Federal St.

5. SEX: male
6. RACE: colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Jan 3, 1950
9. AGE (In years last birthday): 16
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Ruth Staton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Ruth Godsey ADDRESS: 2407 E. Federal St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

E981X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot wound of head
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2407 E. Federal St.

21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 31 (Year) 66 (Hour) 6:00p.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? shot in head

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-14-67
23C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.
23D. LOCATION (City, town, or county): A.A. Co. (State): Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
24B. NAME OF REGISTRAR: Robert E. Falkenhan
24C. FUNERAL DIRECTOR: Morton & Dyer F.H.
ADDRESS: 1701 Lauraens

VS 151-REV. 1/1/65

N8564

M-24 1

67 0290

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

Registered No. 67 0290

CERTIFICATE AMENDED 6-28-67

42

1. NAME OF DECEASED (Type or Print) Josephus McElveen	2. DATE AND HOUR PRONOUNCED DEAD 1/9/67 2:30 p. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION: Sinai Hospital — (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10 D. STREET ADDRESS (If rural, give location): 737 Richwood Rd.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
female	colored		12-23-1923	43				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	ELECTRONIC	Sumpter, South Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
SIAM MCDOWELL	EVELENE SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	220-18-9360	Mr. John McElveen	737 Richwood Street

MEDICAL CERTIFICATION

18. 431X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Subacute, non-specific Myocarditis

(A) ~~Rheumatic Heart Disease~~

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		yes	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-13-67	Arbutus Mem. Park	Arbutus, Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 11 1967	Robert E. Fairbanks	1701 Laurens St.	Morton & Dyett F.H.

0280

VS 151-REV. 1/1/65

Letter from M.E.'s office 6-28-67 M.H.

.BM

1

5-455

67 0291

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 66-23980

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0291

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Michael Sloman	2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 9:30 a. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD — FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 31 City Hospitals	4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: 26-07 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 4215 E. Lombard St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white		11-10-66		2			

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Balto. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Alfred Sloman, Jr.	Roseanna Vest

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS

MEDICAL CERTIFICATION

1B. 325 A

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Interstitial pneumonitis (SDII)

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.	21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/10/67	Sacred Heart	Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 11 1967	Robert E. Fahey	Joseph H. Zamecnik	263 S. Conkling St

VS 151-REV. 1/1/65

H-521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0292 Registered No. 67 0292

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Vincent Venson Hines

2. DATE AND HOUR OF DEATH: 6:15 P.M. Jan. 6th 1967

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore Inc Belvedere Ave at Greenspring Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township):

D. STREET ADDRESS (If rural, give location): 1100 Webb Ct. #32

5. SEX: Male

6. RACE: N.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Dec. 25, 1911

9. AGE (In years last birthday): 55 yrs

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY: Auto. Co.

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Levi Hines

14. MOTHER'S MAIDEN NAME: Betty Motley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-01-4396

17. INFORMANT: Patient's wife ADDRESS:

MEDICAL CERTIFICATION

1B. 260 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Poss. Cerebro Vascular Accident — 12 hrs

DUE TO

(B) Arteriosclerotic Cardio Vascular Disease

DUE TO

(C) Diabetes Mellitus

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-3-67 19 to 1-6-67 19, that (I) (we) last saw the deceased alive on 1-6-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Luk Chang Jang M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-6-67

23C. PHYSICIAN'S NAME (Type): Luk Chang JANG M.D.

23D. ADDRESS: Sinai Hospital of Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-11-67

24C. NAME of CEMETERY or CREMATORY: Arbutus Memorial Pk.

24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Randolph J. Codlick ADDRESS: 2431 E. Oliver St.

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-335

67 0293

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0293

1. NAME OF DECEASED (Type or Print): Bertie Stedding

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 3:49 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 43 South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-01

D. STREET ADDRESS (If rural, give location): 1215 Cooksie St.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 9- 13 - 31

9. AGE (In years last birthday): 35

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator

10B. KIND OF BUSINESS OR INDUSTRY: Parker metal decorating co.

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Greater

14. MOTHER'S MAIDEN NAME: Tine N. Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 216-28-4683

17. INFORMANT: Charles T. Stedding

ADDRESS: 1215 Cooksie St.

MEDICAL CERTIFICATION

18. 466X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pulmonary emboli, originating from veins of pelvis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1 - 13-67

23C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore., Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967

24B. NAME OF REGISTRAR: Robert E. Fankuna

24C. FUNERAL DIRECTOR: Charles L. Stevens Funeral Home, Inc.

ADDRESS: 1501 East Fort Avenue

VS 151-REV. 1/1/65

W-302

BIRTH NO. 67 0294

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0294

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WHITE, LEONARD D.

2. DATE AND HOUR OF DEATH: 1-8-67 3 30 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIV. HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Montg. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): DICKERSON Rural 65-00
D. STREET ADDRESS (If rural, give location):

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 3-28-06
9. AGE (In years last birthday): 60
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GUARD
10B. KIND OF BUSINESS OR INDUSTRY: DETECTIVE
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: FORREST WHITE
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 232-22-5393
17. INFORMANT: WIFE
ADDRESS: S/A

MEDICAL CERTIFICATION

18. 587.0

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute hemorrhagic pancreatitis
DUE TO
(B) c necrosis of liver, gall bladder, pancreas, stomach, & transverse colon
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1-8-66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Acute abd. c̄ mesenteric occlusion
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7/67 19 to 1/8/67 19, that (I) (we) last saw the deceased alive on 1/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stuart L Fine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-8-67
23C. PHYSICIAN'S NAME (Type): STUART L. FINE M.D.
23D. ADDRESS: UNIV HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/67
24C. NAME of CEMETERY or CREMATORY: Monocacy
24D. LOCATION (City, town, or county) (State): Beallsville Beallsville Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 11 1967
25B. NAME OF REGISTRAR: Robert E. Fankuna
26C. FUNERAL DIRECTOR: Constance C. Stelton Stelton Funeral Home
ADDRESS: Barnesville Md.

VS 150-REV. 1/1/65

A-654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0295 Registered No. 67 0295

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Arnold ; George H.

2. DATE AND HOUR OF DEATH: 1/9/67 | 8.30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP. OF BALTIMORE

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: GEORGIA Georgia B. COUNTY: U.S.A.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Lafayette V-09

D. STREET ADDRESS (If rural, give location): 5013 Cordelia Ave

5. SEX: MALE

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1/23/07

9. AGE (In years last birthday): 59

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~XXXXXXXXXXXXXX~~ Private Detective

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry E. Arnold

14. MOTHER'S MAIDEN NAME: Daisy Abney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs. Patricia Morgan, ADDRESS: Annandale, Virginia.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7 1967 to 1/9 1967, that (I) (we) last saw the deceased alive on 8 30 pm 1/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Raphael Pichon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/13/67.

24C. NAME of CEMETERY or CREMATORY: Lafayette Cemetery

24D. LOCATION (City, town, or county) (State): Lafayette, Georgia.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

26B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530

BIRTH NO. 67 0296

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0296

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Katherine M. Smyth

2. DATE AND HOUR PRONOUNCED DEAD: 1/8/67 11:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION: 00
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 5019 Roland Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): 5019 Roland Ave.

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 11/14/1906
9. AGE (In years last birthday): 60
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Boston, Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Meleedy
14. MOTHER'S MAIDEN NAME: Mary Ellen Claffey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Deborah S. Terry, Baltimore, Md.
ADDRESS:

MEDICAL CERTIFICATION

18. E916.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon monoxide poisoning incidental
~~DUE TO~~ to conflagration

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 5019 Roland Ave. 27-13

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 8 (Year) 67 (Hour) ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? housefire

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/11/1967
23C. NAME of CEMETERY or CREMATORY: Belair Mem. Gardens
23D. LOCATION (City, town, or county) (State): Belair, Harford Co., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
24B. NAME OF REGISTRAR: Robert E. Farber, M.D.
24C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Balto. 12, Md.

0275

VS 151-REV. 1/1/65

N968.0

M-517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0297 — Registered No. 67 0297

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): J. Guy Manfuso

2. DATE AND HOUR OF DEATH: 1-10-67 | 11:05 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTO Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 8425 Loch Raven BLVD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 8-5-97
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Gaegano Manfuso
14. MOTHER'S MAIDEN NAME: Elizabeth Barsotti

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213 14 5804
17. INFORMANT: Mrs. Marie J. Manfuso — ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 420.0 — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest — Minutes

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Arterio Sclerotic Heart Disease — Years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Renal Failure; Cerebral Vascul. Accident

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 2 1967 to January 10 1967, that (I) (we) last saw the deceased alive on January 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John G. Green M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: July 11, 1967
23C. PHYSICIAN'S NAME (Type): John G. Green M.D.
23D. ADDRESS: Mercy Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Cem.
24D. LOCATION (City, town, or county) (State): Timonium, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. Balto. Md. — ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-426

BIRTH NO. 67 0298

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0298

1. NAME OF DECEASED (Type or Print): AUGUSTE E. FLICK

2. DATE AND HOUR OF DEATH: January 9, 1967. 2:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 317 E. Lake Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12

D. STREET ADDRESS (If rural, give location): 317 E. Lake Avenue

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: April 6, 1896.

9. AGE (In years last birthday): 70

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Governess

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Adolph F. Flick

14. MOTHER'S MAIDEN NAME: Regina D. Debus

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 103-14-2715

17. INFORMANT: Mrs. Gertrude F. VonHofe

ADDRESS: (Same)

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Coronary Thrombosis — 5 minutes

DUE TO

(B) Coronary atherosclerosis — 4 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from April 1963 to Jan 9 1966, that (I) (we) last saw the deceased alive on Jan 1 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: William F. Fritz M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/10/66

23C. PHYSICIAN'S NAME (Type): William F. Fritz M.D.

23D. ADDRESS: 2 West University Pkway, Balto. Md. 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/12/67.

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: Leonard J. Buck, Inc.

ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-55

BIRTH NO. 67 0299

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0299

1. NAME OF DECEASED (Type or Print): Arthur E. Timanus

2. DATE AND HOUR OF DEATH: 1/10/67 — 9:27 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 1311 Cedaroak Rd

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 6/14/86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipbuilder (~~xxxxxxxx~~)
10B. KIND OF BUSINESS OR INDUSTRY: US Coast Guard Yard
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Timanus
14. MOTHER'S MAIDEN NAME: ? Martin

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-44-8764
17. INFORMANT: Son-in-law - John W. Weller
ADDRESS: Pasadena, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Pulmonary Embolism ~~Acute Coronary Thrombosis~~
DUE TO
(B) Acute Pyelonephritis
DUE TO
(C) ASCVD

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 3/1/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Acute Urinary Retention - Benign Prostatic hypertrophy
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/27 1967 to 1/10 1967, that ~~(I)~~ (we) last saw the deceased alive on 1/10 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: D. A. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): DR. D.A. SCHWARTZ M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/67
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Faber M.D.
25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-230

BIRTH NO. 67 0300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0300

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Lillian L. Dickhaut (Dickhaut)

2. DATE AND HOUR OF DEATH: Jan. 10, 1967 | 4:40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #12 27-48

D. STREET ADDRESS (If rural, give location): 5426 Northwood Dr.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married

8. DATE OF BIRTH: 8/19/~~xx~~92.

9. AGE (In years lost birthday): ~~xxx~~ 74

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk

10B. KIND OF BUSINESS OR INDUSTRY: C&P Telephone Co

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Conrad Dickhaut.

14. MOTHER'S MAIDEN NAME: Louise Fleishman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ~~245~~-05-1892

17. INFORMANT: Elizabeth Forrester (sister)

ADDRESS: 3843 Loch Raven Blvd

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral Hemorrhage

DUE TO

(B) ASCVD

DUE TO Arteriosclerotic Cardiovascular Dis

(C) Cerebral Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 7 1967 to Jan. 10 1967, that (I) (we) last saw the deceased alive on Jan. 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): W. Michael Gould M.D.

23D. ADDRESS: Md. General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/13/67.

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0301 Registered No. 67 0301

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mr. John Hettchen, SR

2. DATE AND HOUR OF DEATH: January 7, 1967 1:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3411 ROSELAWN AVE

37 27-05

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Married	8/31/05	61				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LIEUTENANT	POLICE DEPT	MARYLAND	U.S.A

13. FATHER'S NAME: FRANK P. HETTCHEN

14. MOTHER'S MAIDEN NAME: LULA M. HOLLAND

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS AMELIA HETTCHEN ADDRESS: 3411 ROSELAWN

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Papillary Muscle infarction and Rupture of posterior leaf of mitral valve — Hours

DUE TO

(B) Acute Myocardial Infarction — Days

DUE TO

(C) Arteriosclerotic Cardio-Vascular Disease — Years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 5 1967 to January 9 1967, that (I) (we) last saw the deceased alive on January 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John G Green M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Jan 7, 1967

23C. PHYSICIAN'S NAME (Type): John Gary Green M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1/10/67	PARKWOOD CEMETERY	PARKVILLE MD

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Fahrney	ULRICH FUNERAL HOME	4210 BELAIR

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
P-425

BIRTH NO. 67 0302

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0302

1. NAME OF DECEASED (Type or Print): Jack Paulsen

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 5:02 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21215 27-17
D. STREET ADDRESS (If rural, give location): 2722 Oakley Rd.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 2/25/1926
9. AGE (In years last birthday): 40
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10B. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin H. K. Paulsen
14. MOTHER'S MAIDEN NAME: Ethel Sherrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.: 217-20-6620
17. INFORMANT: Mrs. Gloria D. Paulsen
ADDRESS: 2722 Oakley Ave. 21215

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive internal bleeding
DUE TO
(B) Gunshot wound of chest, involving heart, lungs and aorta
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

E981X

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): rear of 3726 Manchester Ave.
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 9 67 5:00p. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Shot while trying to stop a robbery suspect

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/12/67
23C. NAME of CEMETERY or CREMATORY: Woodlawn
23D. LOCATION (City, town, or county) (State): Baltimore, Md. 21207

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
24B. NAME OF REGISTRAR: Robert E. Faber M.D.
24C. FUNERAL DIRECTOR: Loring Byers
ADDRESS: 8728 Liberty Rd. Randallstown

VS 151-REV. 1/1/65

N879.4

K-400

BIRTH NO. 67 0303

M.E. CASE NO. 92547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0303

1. NAME OF DECEASED (Type or Print): Kelly, Father Frank J.

2. DATE AND HOUR OF DEATH: 4:05, 9-January-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): HOLY-FAMILY RECTORY RANDALLSTOWN Md.

D. STREET ADDRESS (If rural, give location): 53-00

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH: 12-16-1906

9. AGE (In years last birthday): 63

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERGY MAN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Frank J. Kelly

14. MOTHER'S MAIDEN NAME: Margaret Sullivan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-44-8533

17. INFORMANT: Mrs. Margaret K. Keen

ADDRESS: 4613 Northwood Dr. 21212

MEDICAL CERTIFICATION

1B. 150X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) TERMINAL CANCER of ESOPHAGUS — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 31-Dec 1966 to 9-Jan 1967, that (I) (we) last saw the deceased alive on 9-Jan 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: S. R. Park M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 9-Jan-67

23C. PHYSICIAN'S NAME (Type): SAI ROK PARK M.D.

23D. ADDRESS: BON SECOURS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/12/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): 4300 Old Fred.Rd. BAlt. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Talley, MD

25C. FUNERAL DIRECTOR: Loring Byers

ADDRESS: 8728 Liberty Rd. Randallstown

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.
M.E. CASE NO. 67 0304

Registered No. X 67 0304

1. NAME OF DECEASED (Type or Print): Janet Carole Golner

2. DATE AND HOUR OF DEATH: Jan. 9, 1967 | 6:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Public Health Service Hospital, Wyman Pk. Drive & 31st Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: California
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Berkley
D. STREET ADDRESS (If rural, give location): 1825 Tacoma Ave.

V-04

28

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 9/10/48
9. AGE (In years last birthday): 18
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Golner
14. MOTHER'S MAIDEN NAME: Dorothy Robinson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 547-66-6155
17. INFORMANT: Records- US PHS Hospital, Balto, Md.
ADDRESS:

MEDICAL CERTIFICATION

18. 204.3 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH: Acute myelogenous leukemia
INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

(A) DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 23 1965 to Jan. 9 1967, that (I)/(we) last saw the deceased alive on Jan. 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)/(We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel C.H. Lee, M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): Samuel C.H. Lee, Surgeon (R) M.D.
23D. ADDRESS: US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/67
24C. NAME of CEMETERY or CREMATORY: Sunset Cemetery
24D. LOCATION (City, town, or county) (State): Colusa Ave. El Cerrito California

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
26C. FUNERAL DIRECTOR: KRAUSE FUNERAL HOME
ADDRESS: 1216 S. Charles St.

0 5 0 3

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

P-636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0305 Registered No. 67 0305

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARY EMMA PORTER

2. DATE AND HOUR OF DEATH: 1.11.67 | 9 40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 53-00
D. STREET ADDRESS (If rural, give location): 6401 LIBERTY Rd. 21207

5. SEX: FEMALE
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): DIVORCED
8. DATE OF BIRTH: 9.26.01
9. AGE (In years last birthday): 65
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHARLADY (material)
10B. KIND OF BUSINESS OR INDUSTRY: BALTO. CITY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT WASHINGTON PORTER
14. MOTHER'S MAIDEN NAME: ANNIE E. CONNELLY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 215-05-9736
17. INFORMANT: SISTER
ADDRESS: MRS TILGHMAN SHAMER - SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SEPSIS — INTERVAL BETWEEN ONSET AND DEATH: HOURS.
DUE TO
(B) BILATERAL PNEUMONIA — DAYS.
~~DUE TO~~
(C) SEVERE CEREBRAL + generalized arteriosclerosis — 3 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 11 19 66 to JAN 11 19 66, that (I) (we) last saw the deceased alive on JAN 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nina C. Rawlings M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): NINA C. RAWLINGS M.D.
23D. ADDRESS: Md. GENERAL HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: MT. OLIVET
24D. LOCATION (City, town, or county) (State): BALTIMORE, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: GEO. L. SCHWARTZ FUNERAL HOME Francis X. Miller 2101 Frederick Ave.
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-1601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0306 Registered No. 67 0306

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GARRET A. COOPER

2. DATE AND HOUR OF DEATH: JAN. 8, 1967 10:15 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 17-02
D. STREET ADDRESS (If rural, give location): 1025 PENNA. AVE. #17

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced (specify))	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
♂	COLORED	DIVORCED	9/25/97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
VENDOR	FOOD	NORTH CAROLINA	U.S.A

13. FATHER'S NAME: BENJAMIN GEORGE COOPER

14. MOTHER'S MAIDEN NAME: SUTTY QUILES

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-26-3520

17. INFORMANT: JOHN W COOPER ADDRESS: 1821 N FREEMONT AVE

MEDICAL CERTIFICATION

1B. 224X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CARDIO-PULMONARY FAILURE
DUE TO
(B) MYOCARDIAL INFARCTION (?)
DUE TO
(C) POST-OP CRANIOTOMY BRAIN INJURY?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12-27-66	PITUITARY TUMOUR		

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 15 19 66 to January 8 19 67, that (I) (we) last saw the deceased alive on January 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Reynaldo P. Madrinan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: JAN. 8, 1967

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-12-67	National Cem	Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Francis W. Heath & Theodore Heath

ADDRESS: 578 W. Biddle St.

JAN 12 1967

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-5121

BIRTH NO. 67 0307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0307

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary V. Thompson

2. DATE AND HOUR OF DEATH: 1/10/67 — 2 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00
1212 James St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-02
D. STREET ADDRESS (If rural, give location): 1212 James St.

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 2/27/1875
9. AGE (In years last birthday): 91
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Louis
14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mr. Robert Buckingham
ADDRESS: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — 5 Yrs +
~~DUE TO~~
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Bronchopneumonia — 1 day

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1945 19 to 1/10 19 67, that (I) (we) last saw the deceased alive on 1/9/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thos E. Roach M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): Thos E. Roach M.D.
23D. ADDRESS: 5550 Baltimore National Pike Baltimore 14, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: John J. Cowan & Son Inc.
ADDRESS: 90 Holmes St. 25, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-40

67 0308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0308

BIRTH NO. 67-00600

M.E. CASE NO.

1. NAME OF DECEASED (Type) BABY GIRL FAUL

2. DATE AND HOUR OF DEATH 1967 6:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD X21228 53-00

D. STREET ADDRESS (If rural, give location) 107 S BELLEGROVE RD BELLE GROVE

5. SEX FEMALE

6. RACE WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED

8. DATE OF BIRTH 1 8 67

9. AGE (In years last birthday) If Under 1 Yr. Months Days Hours 23 Min. 17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOHN PIERCE FAUL

14. MOTHER'S MAIDEN NAME XX NANCY MILLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ST AGNES HOSP RECORDS

ADDRESS

MEDICAL CERTIFICATION

18. 762.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Atelectasis & hyaline membrane disease

DUE TO

(B) Prematurity

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —

20A. AUTOPSY? (Yes or No) NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7:33 p.m. 8 Jan 1967 to 6:50 p.m. 9 Jan 1967, that (I) (we) last saw the deceased alive on 9 Jan 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Harold Brenner. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED 9 Jan 1967

23C. PHYSICIAN'S NAME (Type) HAROLD BRENNER M.D.

23D. ADDRESS ST AGNES HOSP WILKENS & CATON BALTO MD 29

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 1/11/67

24C. NAME of CEMETERY or CREMATORY LORRAINE

24D. LOCATION (City, town, or county) BALTO. CO. MD. (State)

25A. DATE REC'D BY HEALTH DEPT. JAN 12 1967

25B. NAME OF REGISTRAR Robert E. Tarbuna

25C. FUNERAL DIRECTOR E. S. MALNABIB

ADDRESS 301 FREDERICK RD 21228

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0309 Registered No. 67 0309

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): AQUILIA FREDERICKS

2. DATE AND HOUR OF DEATH: JANUARY 9th 1967 5 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Howard Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): ELLICOTT CITY 63-00
D. STREET ADDRESS (If rural, give location): ROUTE 4

5. SEX: MALE
6. RACE: CAUC.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-4-08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: Balto Transit
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Aquilla FREDERICKS
14. MOTHER'S MAIDEN NAME: Caroline SLIPPERGILL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-05-9412
17. INFORMANT: DANIEL FREDERICKS ADDRESS: College Ave. Ellicott City

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 420.1-260X

(A) PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

DUE TO

(B) MYOCARDIAL INFARCTION — ?

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS — 20 YEARS

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JANUARY 7 19 67 to JANUARY 9 19 67, that (I) (we) last saw the deceased alive on JANUARY 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn B. Lewis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-9-67
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS: M.D. SINAI HOSPITAL OF BALTO.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-12-67
24C. NAME of CEMETERY or CREMATORY: MEADOWRIDGE MEM.
24D. LOCATION (City, town, or county) (State): ELKRIDGE Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: R. E. Fakeme
25C. FUNERAL DIRECTOR: Regina Thomas Fun. Home
ADDRESS: Ellicott City Md

VS 150-REV. 1/1/65

C-5531

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0310 Registered No. 67 0310

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHIEFTAIN M. CONANT

2. DATE AND HOUR OF DEATH: Jan. 8, 1967 9:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 Church Home & Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-24
D. STREET ADDRESS (If rural, give location): 1242 Annisland Way

5. SEX: M
6. RACE: W
7. ~~MARRIED, NEVER MARRIED, WIDOWED,~~ DIVORCED (specify)
8. DATE OF BIRTH: 5-16-1903
9. AGE (In years last birthday): 63
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beth Steel
10B. KIND OF BUSINESS OR INDUSTRY: Iron Worker
11. BIRTHPLACE (State or foreign country): Nova Scotia
12. CITIZEN OF WHAT COUNTRY?: Canada

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 186 03 6627
17. INFORMANT: Son, Robert Conant — ADDRESS: 924 Springbrook

MEDICAL CERTIFICATION

18. 527.1 I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

(B) Pulmonary Cyanosis

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?: —

22. I certify that (I) (this hospital) attended the deceased from Jan 2 1967 to Jan. 8 1967, that (I) (we) last saw the deceased alive on Jan. 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nenita Suarez M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-8-67
23C. PHYSICIAN'S NAME (Type): NENITA SUAREZ M.D.
23D. ADDRESS: Church Home & Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/67
24C. NAME of CEMETERY ~~or CREMATORY~~: Meadowridge Memorial Park
24D. LOCATION (City, town, or county) (State): Howard County, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley
25C. FUNERAL DIRECTOR: Wm F. Crack — ADDRESS: 1211 Chesaco Ave.

VS 150-REV. 1/1/65

R-306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0311 Registered No. 67 0311

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ~~Adele M. Ruth~~ Adele M. Ruth

2. DATE AND HOUR OF DEATH: Jan. 8, 1967 | 10 a. m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 312 S. Augusta Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto. 20-08

D. STREET ADDRESS (If rural, give location): 312 S. Augusta Ave.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Oct. 12, 1905

9. AGE (In years last birthday): 61

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shopping Service

10B. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Samuel Morris

14. MOTHER'S MAIDEN NAME: Carrie Ruth

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Sue Hathaway 312 S. Augusta Ave. Balto. 29. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebral vascular accident — 12 hrs

DUE TO

(B) Hypertensive - Cardio

DUE TO

(C) Vascular disease — 3 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 1966 to Jan 8 1967, that (I) (we) last saw the deceased alive on Jan 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Homer U. Todd M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): Homer U. Todd M.D.

23D. ADDRESS: 2108 St. Paul St

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-11-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: G. Truman Schwab

ADDRESS: 3512 Frederick Ave. Balto.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-438

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0312

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0312

1. NAME OF DECEASED (Type or Print): JOHN E. SLAYTON

2. DATE AND HOUR OF DEATH: JANUARY 8, 1967 11:43 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL, WILKENS & CATON AVENUE, BALTIMORE 29, MARYLAND

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Howard Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): COLUMBIA 63-00
D. STREET ADDRESS (If rural, give location):

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 1-10-29
9. AGE (In years last birthday): 37
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANAGER
10B. KIND OF BUSINESS OR INDUSTRY: THE ROUSE CO.
11. BIRTHPLACE (State or foreign country): CONNECTICUT
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY W. SLAYTON
14. MOTHER'S MAIDEN NAME: WINIFRED

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): KOREA
16. SOCIAL SECURITY NO.:
17. INFORMANT: ST. AGNES HOSPITAL, WILKENS & CATON AVE.
ADDRESS:

MEDICAL CERTIFICATION

18. 330 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Subarachnoid hemmorrhage, Spontaneous — 12 hrs.
DUE TO
(B) Arterial aneurysm, congenital — 37 yrs?
DUE TO
(C) Post. Communic. Artery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER. 1-23-67

19A. DATE OF OPERATION: 1/3/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: SAME
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JANUARY 8 19 67 to JANUARY 8 19 67, that (I) (we) last saw the deceased alive on JANUARY 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W E Signor M.D. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/9/67
23C. PHYSICIAN'S NAME (Type): W.E. SIGNOR, M.D. M.D.
23D. ADDRESS: ST. AGNES HOSPITAL, WILKENS & CATON AVE.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-10-67
24C. NAME of CEMETERY or CREMATORY: St Johns
24D. LOCATION (City, town, or county) (State): Ellicott City Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Fankenna
25C. FUNERAL DIRECTOR: Higgabottom Funeral Home
ADDRESS: Ellicott City Md.

VS 150-REV. 1/1/65

C-45

BIRTH NO. 67 0313

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0313

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): William P. Collins

2. DATE AND HOUR OF DEATH: 1-9-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Anderson Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 28-41
D. STREET ADDRESS (If rural, give location): 3605 Gwynn Oak Ave

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10-20-1887
9. AGE (In years last birthday): 79
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor - B&O
10B. KIND OF BUSINESS OR INDUSTRY: RR
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William P Collins
14. MOTHER'S MAIDEN NAME: Catherine Geigan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret F. Collins - Same ADDRESS:

MEDICAL CERTIFICATION

18. 420.0

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Thrombosis — 24 hours
DUE TO
Recurrent
(B) Broncho-pneumonia — 2 days
DUE TO
(C) Arteriosclerotic Heart Disease — 10 years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Generalized Arteriosclerosis — —

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 12 1962 to Jan. 9 1967, that (I) (~~we~~) last saw the deceased alive on Jan. 9 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Earl L. Chambers M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): Earl L. Chambers M.D.
23D. ADDRESS: 4108 Liberty Hts Baltimore Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Ellsworth Armacost ADDRESS: 4600 Lib Hights Ave

VS 150-REV. 1/1/65

F-236

BIRTH NO. 67 0314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0314

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HESTER FOSTER

2. DATE AND HOUR OF DEATH: 1/10/67 | 11:45 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSPITAL OF MARYLAND

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): ROLANDVIEW TOWERS 3820 Roland Avenue

1307

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	WIDOW	6/16/93	73		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home		Baltimore	USA

13. FATHER'S NAME: Fred Heisse

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Anna Minton — ADDRESS: 616 Aldershot Road

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CVA LEFT

DUE TO

(B) ASHD

DUE TO

(C) Refractory Anemia

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1/6/67	Refractory Anemia	yes	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
	While At Work ☐ Not While At Work ☐	

22. I certify that (I) (this hospital) attended the deceased from 12/25/66 19 to 1/10 19 67, that (I) (we) last saw the deceased alive on 1/10/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Desiderio L. Hebron, Jr. M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): Desiderio L. Hebron, Jr. M.D.

23D. ADDRESS: Lutheran Hospital of Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-12-67	Druid Ridge Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Falkenhan	Elsworth Funeral Home	4600 Liberty Hghts. Avenue

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536

BIRTH NO. 67 0315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0315

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEONARD ANDERSON

2. DATE AND HOUR OF DEATH: JAN 10 1967 | 7:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto

D. STREET ADDRESS (If rural, give location): 1400 Fordham Ave.

20-08

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 9/17/04

9. AGE (In years last birthday): 62

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self employed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: L. B. Anderson

14. MOTHER'S MAIDEN NAME: Anna Hull

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-01-9879

17. INFORMANT: daughter - M. Hines

ADDRESS: #8 1012 Kingston

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Pulmonary Edema

DUE TO

(B) Congestive Heart Failure

DUE TO

(C) Arteriosclerotic Cardiovascular Disease and Primary Myocardial Disease

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/13 1967 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald Godley M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: Md General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-14-67

24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Elsworth Funeral Home

ADDRESS: 4600 Liberty Hghts. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0316 North Carolina

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0316

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LILLIE N. DAVIS

2. DATE AND HOUR PRONOUNCED DEAD: January 6, 1967 6:50 A. M.

CERTIFICATE AMENDED 3-22-67

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 2636 Garret Avenue

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-07
D. STREET ADDRESS (If rural, give location): 2636 Garret Avenue

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: Nov 13, 1966
9. AGE (In years last birthday): If Under 1 Yr. Months: 2 Days: Hours: If Under 24 Hrs. Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: James A. Dickens
14. MOTHER'S MAIDEN NAME: Delorse Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Delorse Davis ADDRESS: 2636 Garrett Ave.

MEDICAL CERTIFICATION

18. 491

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Acute bronchopneumonia

(A) ~~Interstitial pneumonitis (SDII)~~

DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/10/67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetery
23D. LOCATION (City, town, or county) (State): Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
24B. NAME OF REGISTRAR:
24C. FUNERAL DIRECTOR: Wm C March ADDRESS: 928 E. North Ave.

VS 151-REV. 1/1/65

Letter from M.E.'s office 3-22-67 M.H.

L-001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0317 Registered No. 67 0317

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LEE, CULLEN

2. DATE AND HOUR OF DEATH: 1/9/67 3 20 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-47
D. STREET ADDRESS (If rural, give location): 3025 WINDSOR AVE

5. SEX: M
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 7-26-87
9. AGE (In years last birthday): 79
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 214-14-7342
17. INFORMANT: Rev Ella Smith ADDRESS: 2620 Shirley Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 4 4 3 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) UREMIA
DUE TO
(B) ASHCVD
DUE TO
(C) PNEUMONIA

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN. 8 19 67 to JAN 9 19 67, that (I) (we) last saw the deceased alive on JAN 9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Young Kil Kim M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/9/67
23C. PHYSICIAN'S NAME (Type): YOUNG KIL KIM M.D.
23D. ADDRESS: LUTHERAN HOSPITAL OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/67
24C. NAME of CEMETERY or CREMATORY: Mt. Calvary Ce
24D. LOCATION (City, town, or county) (State): Anne Arundel Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Fanburna
25C. FUNERAL DIRECTOR: Wm. J. Marsh ADDRESS: 928 E. North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0318 Registered No. 67 0318

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dora Heathcote

2. DATE AND HOUR OF DEATH: Jan. 6, 1967 7 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3808 Frankford Ave. 6

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 3808 Frankford Ave. 6

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md. 27-34

D. STREET ADDRESS (If rural, give location): 3808 Frankford Ave. 6

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Widow	Nov. 6, 1877	~~89~~ 89		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	---	Balto. Md.	

13. FATHER'S NAME: Theodore Ludwig

14. MOTHER'S MAIDEN NAME: Caroline Diebel

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
--	----	215-48-4566	Miss Florence Ludwig	3808 Frankford Ave. 6

MEDICAL CERTIFICATION

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary occlusion

DUE TO Coronary sclerosis

(B) Hypertension

DUE TO

(C) Arteriosclerosis Heart

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Anemia

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 31 1966 to Jan 6 1967, that (I) (we) last saw the deceased alive on Jan 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Walter A. Anderson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan 7-67

23C. PHYSICIAN'S NAME (Type) M.O.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan. 9, 1967	Baltimore Cem.	Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Tolbert	Philip Herwig Sons	2024 Orleans St

VS 150-REV. 1/1/66

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-67

BIRTH NO. 67 0319

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0319

1. NAME OF DECEASED (Type or Print): WALTER HOWARD

2. DATE AND HOUR OF DEATH: 1-11-1967 9.25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 NORTH CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 2708 E. JOPPA Rd.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-10-91

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MOTORMAN

10B. KIND OF BUSINESS OR INDUSTRY: BALTO. TRANSIT CO.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSHUA HOWARD

14. MOTHER'S MAIDEN NAME: Helen B Megginson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-2983

17. INFORMANT: NORTH CHARLES GEN. HOSP. CHART.

ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) CEREBRO-VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 2-4 days

DUE TO

(B) Hypertensive ASCVD — 10 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-31 1966 to 1-11 1967, that (I) (we) last saw the deceased alive on 1-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr. Juan F. Oleman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-11-1967

23C. PHYSICIAN'S NAME (Type): DR. SHELDON GOLDGEIER M.D.

23D. ADDRESS: 848 W. 36th St. BALTO. Md. 21218

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-14-67

24C. NAME of CEMETERY or CREMATORY: POPLAR GROVE

24D. LOCATION (City, town, or county) (State): BALTO Co Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: CHAS F. EVANS + SON

ADDRESS: 8802 HARFORD Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-650

BIRTH NO. 67 0320

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0320

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Margaret Freeney

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 1:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 114 E. Eager St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-01

D. STREET ADDRESS (If rural, give location): 114 E. Eager St.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): single

8. DATE OF BIRTH: Nov 11 1887

9. AGE (In years last birthday): 80

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): stenographer

10B. KIND OF BUSINESS OR INDUSTRY: Bus. zoffice

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Personal records ADDRESS

MEDICAL CERTIFICATION

1B. 422.1

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/12/67

23C. NAME of CEMETERY or CREMATORY: New Cathedral

23D. LOCATION (City, town, or county) (State): Balto Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

24B. NAME OF REGISTRAR: Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR: C. F. EVANS & SON ADDRESS: 8802 Harford rd.

VS 151-REV. 1/1/65

E-2613

67 0321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0321

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ECKERT ELIZABETH C.

2. DATE AND HOUR OF DEATH: 9 JAN. 1967 | 5 45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 8538 WILLOW OAK ROAD

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 05-31-'99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: HENRY HOEFNER

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-10-0606

17. INFORMANT: A Bernard E. Eckert, Jr.

ADDRESS: Box 132, Rt.15, Middle River, Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 502.01

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Focal Bronchopneumonia & Bronchitis

DUE TO

(B) Pulmonary Emphysema

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

A. Hippolito, M.D.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12 – 29 1966 to 1 – 9 1967, that (I) (we) last saw the deceased alive on 1 – 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjofur Bjornsson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-9 '67

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSP

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/12/67

24C. NAME of CEMETERY or CREMATORY: Glen Haven Memorial Park

24D. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert C. Talbert

25C. FUNERAL DIRECTOR: Robert C. Altenburg-Funeral Home, Inc.

ADDRESS: 6009 Harford Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-456

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0322

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): KLEIN PETER

2. DATE AND HOUR OF DEATH: 1-10-67 | 6:40 P.M.

CERTIFICATE AMENDED

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital. 4/17/67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore FOS
D. STREET ADDRESS (If rural, give location): 2207 E. Baltimore Str.

35

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ~~Widowed~~
8. DATE OF BIRTH: 5/14/85
9. AGE (In years last birthday): 81
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NIGHT WATCHMAN
10B. KIND OF BUSINESS OR INDUSTRY: [illegible]
11. BIRTHPLACE (State or foreign country): HUNGARY
12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: MARK C. KLEIN
14. MOTHER'S MAIDEN NAME: MAGDELENA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give dates of service)
16. SOCIAL SECURITY NO. 219-12-6985
17. INFORMANT: Arch Beard — ADDRESS: 1631 Northeast 56th St. Fort Lauderdale, Florida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

420.0

(A) Arteriosclerotic heart disease — 35 days.
DUE TO
(B) ~~Fracture of hip~~
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY CHIEF OR ASST. CHIEF MEDICAL EXAMINER

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 12/5/66 19 to 1/10/67 19, that I (we) last saw the deceased alive on 1/10/ 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.

23A. SIGNATURE: I. R. Anderson M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/10/66
23C. PHYSICIAN'S NAME (Type): Ian R. Anderson M.D.
23D. ADDRESS: Church Home & Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/12/67
24C. NAME of CEMETERY or CREMATORY: Holy Cross Cem
24D. LOCATION (City, town, or county) (State): AA Co Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert C. Farley M.D.
25C. FUNERAL DIRECTOR: McCully F H — ADDRESS: 237 Patapsco Ave 21225

VS 158-REV. 1/1/65

Affidavit statement from widow of decedent re latter's marital status.
Letter from informant re Soc.Sec.No. & War Service.

S-260

BIRTH NO. 67 0323

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0323

1. NAME OF DECEASED (Type or Print): SIEGER, FRANCES M

2. DATE AND HOUR OF DEATH: 1-9-67 12:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 307 BLOOMBURY AVE. 21228

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 11-24-90

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? BURNS

14. MOTHER'S MAIDEN NAME: ? STEWARD

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ST AGNES HOSPITAL RECORDS, WILKENS AND CATON AVES.

ADDRESS: 21229

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 152X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-4- 19 67 to 1-9-67 19 , that (I) (we) last saw the deceased alive on 1-9- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Pablo E. Dibos M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-9-67

23C. PHYSICIAN'S NAME (Type): PABLO E DIBOS MD

23D. ADDRESS: ST AGNES HOSP WILKENS & CATON BALTO 29 MD

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/12/67

24C. NAME of CEMETERY or CREMATORY: MEADOWRIDGE

24D. LOCATION (City, town, or county) (State): HOWARD CO. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: J. S. MACNABB

ADDRESS: 301 FREDERICK RD 21228

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-6210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0324 Registered No. 67 0324

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clyde Thomas Harris

2. DATE AND HOUR OF DEATH: 1/11/67 | 12:30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Bar. Wil 13A Cold 2101 W. Cold Spring La.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 1902 E. Fairmount Ave.

5. SEX: M.
6. RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W.
8. DATE OF BIRTH: 9/9/92
9. AGE (In years last birthday): 74
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unk George Harris
14. MOTHER'S MAIDEN NAME: Unk Belle Brown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 172-01-2621A
17. INFORMANT: Ralph Robinson ADDRESS: 203 N. 45th St. Harrisburg, P.A.

Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 136.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of the liver: primary site unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-23- 1966 to 1-11- 1967, that (I) (we) last saw the deceased alive on 1-9- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C.R. Campbell, M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-12-67
23C. PHYSICIAN'S NAME (Type): C.R. Campbell, M.D.
23D. ADDRESS: 1618 W. North Ave. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Fabiyna
25C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
T-630

67 0325

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 0325

BIRTH NO.

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ERNEST TREAT

2. DATE AND HOUR PRONOUNCED DEAD: January 10, 1967 | 11:10 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08

D. STREET ADDRESS (If rural, give location): 1206 Bonaparte Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Colored	Married	May 5, 1915	51				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Farmville, Va.	

13. FATHER'S NAME: David Threat

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-01-1088

17. INFORMANT: Nannie Threat

ADDRESS: 1206 Bonaparte Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

E981X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gunshot Wound of Chest

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Basement Bar

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 926 N. Gay Street

21D. TIME OF INJURY (APPROX.) (Month) 1 (Day) 10 (Year) '67 (Hour) 9:30P m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Was shot in chest.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: 1/11/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/14/67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetery

23D. LOCATION (City, town, or county) (State): Anne Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

24B. NAME OF REGISTRAR: Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR: Wm March

ADDRESS: 928 E. North Ave.

VS 151-REV. 1/1/65

N8-23-4

1967 0 0 0 8 2 7

W-20

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0326 Registered No. 67 0326

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN WEISS

2. DATE AND HOUR OF DEATH: 10 January 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2318 Mayfield Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore City 1-03
D. STREET ADDRESS (If rural, give location): 603 S. Milton Ave.

5. SEX: Male
6. RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 2 July 1888
9. AGE (In years last birthday): 78
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maintanence
10B. KIND OF BUSINESS OR INDUSTRY: Can Mfr.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Weiss
14. MOTHER'S MAIDEN NAME: Anna Bloom

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-10-5984
17. INFORMANT: Wilson Rohde, 2318 Mayfield Ave. 21213 ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1/31 1948 to Jan 10 1967, that (I) (~~we~~) last saw the deceased alive on Jan 9 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: L B Stevens M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): L.B. Stevens M.D.
23D. ADDRESS: 3400 Erdman Ave. 21213

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore County, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Albert E. Fairbanks
25C. FUNERAL DIRECTOR: Ullrich Funeral Home, Baltimore, Md. ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0327 Registered No. 67 0327

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Blanche M. Kirby

2. DATE AND HOUR OF DEATH: 1-10-67 3:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 26-03

D. STREET ADDRESS (If rural, give location): 3515 Cliftmont Avenue

5. SEX: F

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 6-26-06

9. AGE (In years last birthday): 60

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Niblett

14. MOTHER'S MAIDEN NAME: Elsie Carl

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO.

16. SOCIAL SECURITY NO.:

17. INFORMANT: HARRY KIRBY, SR. ADDRESS: 3515 CLIFTMONT

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 170X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse Carcinomatosis

DUE TO 2° to Primary Carcinoma of Breast

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 01/19/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pathologic Fx Femur (R)

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (this hospital) attended the deceased from 11/19/66 19 66 to 1/10 19 67; that ~~I~~ (we) last saw the deceased alive on 1/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (did ~~not~~) view the body after death.

23A. SIGNATURE: D. A. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): DAVID S. SCHWARTZ M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/13/67

24C. NAME of CEMETERY or CREMATORY: PARKWOOD CEMETERY

24D. LOCATION (City, town, or county) (State): PARKVILLE MD

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: ULRICH FUNERAL HOME ADDRESS: 4120 BELAIR

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V 4531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0328
M.E. CASE NO.

Registered No. 67 0328

1. NAME OF DECEASED (Type or Print): Nancy Lee Valentine

2. DATE AND HOUR OF DEATH: Jan. 10, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1516 Mt. Royal Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1516 Mount Royal Ave.

5. SEX: F
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 7-10-12
9. AGE (In years last birthday): 54
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Lewis
14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 247346425
17. INFORMANT: Lizzie S. Bivins
ADDRESS: 1516 Mount Royal Ave

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I 120 X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast — 3 YRS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/10/1964 to 1/10/1967, that (I) (we) last saw the deceased alive on 1/8/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John S. Braxton Jr. M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/12/67
23C. PHYSICIAN'S NAME (Type): JOHN S. BRAXTON JR M.D.
23D. ADDRESS: 922 S Stap, Balt 30, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Arbutus, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farkas M.D.
25C. FUNERAL DIRECTOR: George G. Kelson
ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-33-55 ED

J-520

BIRTH NO. 67 0329

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0329

1. NAME OF DECEASED (Type or Print): Robert GEORGE JONES.

2. DATE AND HOUR OF DEATH: 1-11-67 | 6^40 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 15-04

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2008 Smallwood Street 21216

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	Negro	Married	11/4/13	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Virginia	U.S.A.

13. FATHER'S NAME: George

14. MOTHER'S MAIDEN NAME: Lucy Epps

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-09-2583

17. INFORMANT: BCH: Records 4940 Eastern Ave. Balto., Md.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 133.01

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) E. coli septicemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

(B) Hepatoma - metastatic

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary tract infection, decubiti

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-19 1966 to 1-11 1967, that (I) (we) last saw the deceased alive on 1-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Carlos R. Hamilton Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-11-67.

23C. PHYSICIAN'S NAME (Type): Carlos R. Hamilton Jr. M.D.

23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-15-67	Church Cemetery	Blackstone, Virginia

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Farley M.D.	George G. Kelson	1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-434

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0330 Registered No. 67 0330

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GUSSIE CALDWELL

2. DATE AND HOUR PRONOUNCED DEAD: January 5, 1967 2:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1696 Pierce Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 696 Pierce Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Female	Negro			45				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?			

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

1B. 443X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED January 6, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/12/67	Mt Calvary Cemetry	A A County Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Fahrney	Adolphus Halstead	1206 W North Ave

VS 151-REV. 1/1/65

P.3621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0331 Registered No. 67 0331

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): LILLIAN PETERSON

2. DATE AND HOUR OF DEATH: 1/9/67 6 55 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIV. HOSP

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: 1801
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 834 Vine Street

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)
8. DATE OF BIRTH
9. AGE (In years last birthday): 65
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Peterson ADDRESS: 834 Vine St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) post-cardiac resuscitation — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) HASCVD C CHF + mild pulmonary edema

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/5/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: tracheotomy
20A. AUTOPSY? (Yes or No): ✓
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/5 1967 to 1/9 1967, that (I) (we) last saw the deceased alive on 1/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Anne C. Colston M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ✓
23B. DATE SIGNED: 1/9/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cemetry
24D. LOCATION (City, town, or county) (State): A A County Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Tolley M.D.
25C. FUNERAL DIRECTOR: Adolphus Halstead ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
W. 123

67 0332

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0332

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles K. Webster

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 10:01 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 2-02

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 236 S. Ann St.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 1-15-1912

9. AGE (In years last birthday): 54

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SANITATION DEPT.

10B. KIND OF BUSINESS OR INDUSTRY: BALTO CITY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN WEBSTER

14. MOTHER'S MAIDEN NAME: MARGARET GRAHAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-9855

17. INFORMANT: HELEN WEBSTER

ADDRESS: 236 S. ANN ST.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/9/67

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

23B. DATE: 1-13-67

23C. NAME of CEMETERY or CREMATORY: HOLY ROSARY CEM

23D. LOCATION (City, town, or county): BALTO (State): MARYLAND

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: JOHN M WEBER & SONS INC

ADDRESS: 401 S. CHESTER ST.

VS 151-REV. 1/1/65

1

5.520

67 0333

BALTIMORE CITY HEALTH DEPARTMENT

67 0333

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edward L. Schwanke

2. DATE AND HOUR PRONOUNCED DEAD: 1/10/67 12:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 31 City Hospitals

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 26-44

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 4306 Baltimore St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
male	white	MARRIE	6-7-1913	53				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LONGSHOREMAN		MARYLAND	USA

13. FATHER'S NAME: LOUIS SCHWANKE

14. MOTHER'S MAIDEN NAME: CECILIA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: FRANCES E. SCHWANKE

ADDRESS: 4306 BALTIMORE ST.

MEDICAL CERTIFICATION

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic cardiovascular disease

~~DUE TO~~ associated with calcific aortic stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		yes	yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
BURIAL	1-14-67	HOLY ROSARY CEM	BALTO, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Farber M.D	~~JOHN~~ WEBER FUNERAL HOME	5311 EDMONDSON AVE.

VS 151-REV. 1/1/65

K-25-2

BIRTH NO. 66-25617 67 0334
M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0334

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): James M. Kaczynski
2. DATE AND HOUR OF DEATH: 1/11/67 12:45 PM.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: Maryland; B. COUNTY; C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore; D. STREET ADDRESS (If rural, give location): 2326 Fleet Street

33 103

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
Male	White	Child	12/2/66		1	9		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Baltimore, Maryland	

13. FATHER'S NAME: Theodore Kaczynski
14. MOTHER'S MAIDEN NAME: Patricia Chase

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		No	Theodore Kaczynski	2326 Fleet Street

MEDICAL CERTIFICATION

1B. 0320 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Renal failure & acidosis — ~1 da.
DUE TO
(B) Glomerulonecrosis — ~1 da.
DUE TO
(C) Meningococcal septicemia and meningitis — 2½ da.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes - complete	No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 9 1967 to January 11 1967, that (I) (we) last saw the deceased alive on January 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Elliott M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): J. Elliott
23D. ADDRESS: CMSC - Johns Hopkins Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-12-1967	Holy Rosary	Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Fordyce	Lilly & Zeiler Inc.	1901-07 Eastern Ave.

VS 150-REV. 1/1/65

A-12 J

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0335 Registered No. 67 0335

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM HENRY HOPKINS SR

2. DATE AND HOUR OF DEATH: 1/9/67 11:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital

38

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Delaware B. COUNTY: Sussex

C. CITY OR TOWN (If outside city limits, write RURAL and give township): SEAFORD

V-07

D. STREET ADDRESS (If rural, give location): 1001 WINDSOR ROAD

5. SEX: MALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: FEB 15, 1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY: SHIPBUILDING

11. BIRTHPLACE (State or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES W. HOPKINS

14. MOTHER'S MAIDEN NAME: SARAH (UNKNOW)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 222-01-8052

17. INFORMANT: JAMES M. HOPKINS

ADDRESS: SEAFORD, DEL.

MEDICAL CERTIFICATION

1B. 167 X

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic epidermoid carcinoma of the larynx

INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia

19A. DATE OF OPERATION: 12/13/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Airway Obstruction

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 6 1966 to Jan 9 1967, that (I) (we) last saw the deceased alive on Jan 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Leighton Siegel M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): Leighton Siegel M.D.

23D. ADDRESS: University Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: JAN 12 1967

24C. NAME of CEMETERY or CREMATORY: MACEDONIA CEMETERY

24D. LOCATION (City, town, or county) (State): SEAFORD, DELAWARE

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Falkenna

25C. FUNERAL DIRECTOR: Catherine M. Barrancos-Siverna

ADDRESS: Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-656

BIRTH NO. 67 0336

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0336

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Robert Parran

2. DATE AND HOUR OF DEATH: 10 Jan 1967 | 6:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 91 Montebello Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 712 Brune St.

5. SEX: M
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10 Feb 1886
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home by history
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Parran
14. MOTHER'S MAIDEN NAME: not known

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-09-8329
17. INFORMANT: Gladys Gray (step-daughter) ADDRESS: 2235 Hilton St. Baltimore Md

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute glomerulonephritis c about right kidney — 11 months
DUE TO
(B) ASCVD c chronic congestive heart failure
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-7 1966 to 10 Jan 1967, that (I) (~~we~~) last saw the deceased alive on 10 Jan 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Charles H. Rockers M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 10 Jan 67
23C. PHYSICIAN'S NAME (Type):
23D. ADDRESS M.D.: Montebello Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemt
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Harrison W. Cooper, Joseph H. Rum
ADDRESS: 572 N. Carrollton Av.

VS 150-REV. 1/1/65

13-150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0337 Registered No. 67 0337

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GRACE BIRCH

2. DATE AND HOUR OF DEATH: January 11, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1506 Abbotston Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1506 Abbotston Street

9-07

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Feb. 5,1920
9. AGE (In years last birthday): 46
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Dudley Foster
14. MOTHER'S MAIDEN NAME: Nannie Burford
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 226-05-8601
17. INFORMANT: John B. Birch ADDRESS: 1506 Abbotston Street

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 581.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of Liver - alcoholic — 7

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C) Myocardial Failure — 2 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/1 1963 to 1/11 1967, that (I) (we) last saw the deceased alive on 1/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph S. Blum M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/12/67
23C. PHYSICIAN'S NAME (Type): JOSEPH S. BLUM M.D.
23D. ADDRESS: 1115 N. CALVERT ST.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan.14,1967
24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cementery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 12 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm Cook-Brooks Inc. ADDRESS: 1217 St Paul & Preston

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0338 Registered No. 67 0338

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSIAH A. NORTHUP

2. DATE AND HOUR OF DEATH: 1/11/67 1:25 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP. OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3312 Lyndale Ave.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 10/22/87
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10B. KIND OF BUSINESS OR INDUSTRY: Electrical
11. BIRTHPLACE (State or foreign country): WARSAW, VIRGINIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FREDERICK NORTHUP
14. MOTHER'S MAIDEN NAME: LEAFIE LOWRY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 217-03-9858
17. INFORMANT: Hospital Records
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Pulmonary failure
DUE TO
(B) Possible Myocardial Infarction
DUE TO
(C) a Pulmonary Embolism.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/11/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Acute Cholecystitis
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~I~~ (~~this hospital~~) attended the deceased from Jan. 1, 1967 to Jan. 11, 1967, that ~~I~~ (we) last saw the deceased alive on Jan. 11, 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Francisco D. Sabado, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): FRANCISCO D. SABADO JR. M.D.
23D. ADDRESS: SINAI HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: St. Johns Episcopal Cem.
24D. LOCATION (City, town, or county) (State): WARSAW VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. Cook & Brooks Towson Inc
ADDRESS: 1050 York Rd Towson, Md. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-361

BIRTH NO. 67 0339

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0339

1. NAME OF DECEASED (Type or Print): Peter F. STreb

2. DATE AND HOUR OF DEATH: Jan. 9, 1967 | 8:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~Baltimore~~ TOWSON 53-00

D. STREET ADDRESS (If rural, give location): 1011 Kenilworth Dr.

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 7/15/97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10B. KIND OF BUSINESS OR INDUSTRY: SAVINGS & LOAN CO.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A. STreb

14. MOTHER'S MAIDEN NAME: Isabell McDougal

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-09-9528

17. INFORMANT: Elizabeth Perantku (daughter)

ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage

DUE TO ASHCVD. and As hypertensive

(B) Cerebral Vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 9 1967 to Jan 9 1967, that (I) (we) last saw the deceased alive on Jan 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-13-67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR: Wm Cook Brooks Towson

ADDRESS: 1050 YORK ROAD TOWSON, MD. 21204

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0340 Registered No. 67 0340

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anthony Frank Sadzenski

2. DATE AND HOUR OF DEATH: January 12, 1967 | 12:10 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 705 S. Glover Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

-03

D. STREET ADDRESS (If rural, give location): 705 S. Glover Street

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Widowed	7/13/97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Crown, Cork & Seal Co.	Poland	U. S. A.

13. FATHER'S NAME: Martin Sadzenski

14. MOTHER'S MAIDEN NAME: Sophia Felczak

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-10-6065

17. INFORMANT: Walter Sadzenski — ADDRESS: 206 Henry Avenue #21206

CAUSE OF DEATH

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	MYOCARDIAL INFARCTION	instantaneous
(B) DUE TO	ARTERIOSCLEROTIC HEART D.	13 years
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Wolff-Parkinson-White Syndrome

MEDICAL CERTIFICATION

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from APRIL 1953 to JANUARY 12 1967, that (I) (~~we~~) last saw the deceased alive on DEC 12 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Richard D Hahn M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: January 12, 1967

23C. PHYSICIAN'S NAME (Type): RICHARD D HAHN M.D.

23D. ADDRESS: 1010 SAINT PAUL ST.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/16/67	Holy Rosary Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Faherty

25C. FUNERAL DIRECTOR: George A. Weber — ADDRESS: 705 S. Ann St. — #21231

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released to The Johns Hopkins Hospital on approval from M.E. 55 25 33 P PIERCY, ESTHER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620

BIRTH NO. 67 0341

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0341

1. NAME OF DECEASED (Type or Print): Piercy, Esther June

2. DATE AND HOUR OF DEATH: Jan 10 1967 4 50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 801 1/2 Cathedral St
D. STREET ADDRESS (If rural, give location):

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F	Wh	Single	06-15-05	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: PIERCY, Watt Brown

14. MOTHER'S MAIDEN NAME: ? Margaret Henderson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Watt Piercy — ADDRESS: 1381 Arrington Road Hillsboro, Oregon

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Subarachnoid hemorrhage
DUE TO (B) Subdural hemorrhage
DUE TO (C) ~~Probable ASCVD~~ Skull Fx
DUE TO fell on floor

48 hrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): yes

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): home 801 1/2 Cathedral St.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 8 66 ~3 PM

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑

21F. HOW DID INJURY OCCUR?: Pt. fell

22. I certify that (I) (this hospital) attended the deceased from 1/2 1967 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C. P. Wilkinson M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): C. P. Wilkinson M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 1/12/1967

24C. NAME of CEMETERY or CREMATORY: Green Mount Crematory

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Wm. J. Tickner & Sons — ADDRESS: Balto, Md. North & Pa.

VS 150-REV. 1/1/65

F-421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0342 Registered No. 67 0342

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Flora D. Fletcher

2. DATE AND HOUR OF DEATH: January 7, 1967 | 9:00 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5504 Saint Albans Way Baltimore, Maryland 21212

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 5504 Saint Albans Way 21212

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: April 29, 1904
9. AGE (In years last birthday): 62
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): New York, New York
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert J. Fletcher
14. MOTHER'S MAIDEN NAME: Gertrude Ramsey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 063-20-5786
17. INFORMANT: Mr. Robert J. Fletcher
ADDRESS: RFD #1 Box 16 Croton on Hudson, N. Y

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary thrombosis — immediate

DUE TO

(B) cerebro-vascular arteriosclerosis — several yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-29- 1965 to 1-7-67 19 , that (I) (we) last saw the deceased alive on 1-3- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Ellsworth Cook M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-9-67
23C. PHYSICIAN'S NAME (Type): E. ELLSWORTH COOK M.D.
23D. ADDRESS: 2431 Maryland Ave. Balto 21218 Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/9/1967
24C. NAME of CEMETERY or CREMATORY: Kensicoe Cemetery
24D. LOCATION (City, town, or county) (State): Kensicoe, New York

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Jackson
25C. FUNERAL DIRECTOR: W. J. Fichna & Sons
ADDRESS: Balto, Md. North 2 Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0343 Registered No. 67 0343

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Clinton C. Giese

2. DATE AND HOUR OF DEATH: January 8, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 3024 North Calvert Street
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 3024 North Calvert Street 18

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Dec. 14, 1886
9. AGE (In years last birthday): 80
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner - Printing Co.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James H. Giese
14. MOTHER'S MAIDEN NAME: Andasia Sappington

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Beatrice Giese
ADDRESS: same address as above

MEDICAL CERTIFICATION

1B. 177X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Carcinoma of prostate with multiple metastases — 1 year
(B) DUE TO: and death
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 18 Oct. 1966 to 8 Jan 1967, that (I) (we) last saw the deceased alive on 7 Jan 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Joseph E. Muse Jr M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 9 Jan. '67
23C. PHYSICIAN'S NAME (Type): M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/1967
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Kelly M.D.
25C. FUNERAL DIRECTOR: Wm. J. Richmond & Sons
ADDRESS: Balto. Md. Norristown Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0344 Registered No. 67 0344

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Atwood, MRS. ANNA May

2. DATE AND HOUR OF DEATH: 1/10/67 @ 3:50 A.M. P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTO. Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Towson 53-00
D. STREET ADDRESS (If rural, give location): 614 Meadow Ridge Rd.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Nov. 7, 1875
9. AGE (In years last birthday): 90 91 yrs. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Bowen
14. MOTHER'S MAIDEN NAME: Jenperance Shroyer
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-48-7204
17. INFORMANT: Mr. Donald Atwood ADDRESS: 1529 Sheffield Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Head of Pancreas
DUE TO
(B) Arteriosclerotic Cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 11-25 1966 to 1-10 1967 that (we) last saw the deceased alive on 1-10- 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Milagros L. Guerrero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Jan. 10, 1967
23C. PHYSICIAN'S NAME (Type): MILAGROS L. GUERRERO - M.D.
23D. ADDRESS: BON SECOURS HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/1967
24C. NAME of CEMETERY or CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. Lechner & Sons
ADDRESS: Balto., Md. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0345 Registered No. 67 0345

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Emma M. Hooper

2. DATE AND HOUR OF DEATH: January 10, 1967 | 7 30 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 937 Homestead Street Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-05

D. STREET ADDRESS (If rural, give location): 937 Homestead Street 21218

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Aug. 12, 1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Worked

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Greaser

14. MOTHER'S MAIDEN NAME: Alice

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-9627-D

17. INFORMANT: Mrs. Edna C. Brown ADDRESS: same address as above

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic heart disease — years

DUE TO

(B) generalized arteriosclerosis — years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. cerebral thrombosis — 6 years

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov 1960 to 10 Jan 1967, that (I) (we) last saw the deceased alive on 14 Nov 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: W. F. Cox 3d M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 12 Jan 67

23C. PHYSICIAN'S NAME (Type): William F. Cox, III M.D.

23D. ADDRESS: 1118 St. Paul Street

24A. BURIAL CREMATION, REMOVAL (Specify): Bruial

24B. DATE: 1/13/1967

24C. NAME of CEMETERY or CREMATORY: Saint Marys Cemetery

24D. LOCATION (City, town, or county) (State): Silver Run, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Wm. J. Fulton & Sons ADDRESS: Balto, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

M-216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0346 Registered No. 67 0346

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Fred S. McFarline

2. DATE AND HOUR OF DEATH: January 8, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 903 Lake Drive

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-01

D. STREET ADDRESS (If rural, give location): 903 Lake Drive 21217

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Nov. 23, 1873

9. AGE (In years last birthday): 93 | If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Store Manager

10B. KIND OF BUSINESS OR INDUSTRY: Regal & Sons

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam McFarline

14. MOTHER'S MAIDEN NAME: Laura

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

If yes, give war or dates of service: None

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. James McFarline

ADDRESS: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease c Atrial Fibrillation — 6 wks.

DUE TO

(B) Acute Congestive Failure (Heart) — 1 day.

DUE TO

(C) Arteriosclerotic Heart Disease c Coronary Artery Disease — Several Years Duration. Some Years Duration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Traumatic Abrasions following Pelvic Injury — 10 days.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 79 1966 to Jan. 8 1967, that (I) (we) last saw the deceased alive on Jan. 8, 1967 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. William Primakoff M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan. 8, 1967

23C. PHYSICIAN'S NAME (Type): H. WILLIAM PRIMAKOFF M.D.

23D. ADDRESS: Emersonian Apartments

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Wm. J. Tilghman & Son

ADDRESS: Belton, Md. North Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0347 Registered No. 67 0347

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Madeline Mary Kelly

2. DATE AND HOUR OF DEATH: 1/5/67 11:30 AM | 11:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp - Balt.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md B. COUNTY: Charles Chas Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Bel Alton 58-00

D. STREET ADDRESS (If rural, give location): Box 56

5. SEX: F

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): ~~Married~~ Married

8. DATE OF BIRTH: 6-2-10

9. AGE (In years last birthday): 56

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Frank Jordan

14. MOTHER'S MAIDEN NAME: ? Emma Jones

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ? 215-26-0478

17. INFORMANT: John H. Kelly, Bel Alton, Md. ADDRESS

MEDICAL CERTIFICATION

1B. 260 X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Himmel-Stiel-Wilson disease — 5 years

DUE TO

(B) Diabetes M. — 26 years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Urinary Infection

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/2 1967 to 1/5 1967, that (I) (we) last saw the deceased alive on 1/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James E Arnold M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/5/67

23C. PHYSICIAN'S NAME (Type): James Edward Arnold M.D.

23D. ADDRESS: Univ. Hosp Box 138

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-9-67

24C. NAME of CEMETERY or CREMATORY: St. Ignatius

24D. LOCATION (City, town, or county) (State): Chapel Point, Charles Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Fankuna

25C. FUNERAL DIRECTOR: Arehart Funeral Home Inc., La Plata, Md ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

H-200

67 0348

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0348

1. NAME OF DECEASED (Type or Print): Pearl Hayes

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 5:02 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Reisterstown 53-00

D. STREET ADDRESS (If rural, give location): 332 Wallgrove Rd.

5. SEX: female

6. RACE: white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Sept. 30, 1903

9. AGE (In years last birthday): 63

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Jacoby

14. MOTHER'S MAIDEN NAME: Josephine Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-10-3949

17. INFORMANT: Mr. Paul L. Hayes ADDRESS: Kingprussia Pa.

MEDICAL CERTIFICATION

18. 4221

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/12/67

23C. NAME of CEMETERY or CREMATORY: Evergreen Memorial

23D. LOCATION (City, town, or county) (State): Finksburg, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

24B. NAME OF REGISTRAR: Robert E. Farkuson

24C. FUNERAL DIRECTOR: J. F. Eline & Sons ADDRESS: Reisterstown, Md.

VS 151-REV. 1/1/65

L-501

THE BODY OF MARGARET S. LONG WAS RELEASED TO THE JOHNS HOPKINS HOSPITAL ON APPROVAL BY DR. KORNBLUH, CHIEF EXAM OFFICE

FUNERAL DIRECTOR: THE MERCANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. Calvert Co. Md. 67-0349

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0349

1. NAME OF DECEASED (Type or Print): MARGARET LONG

2. DATE AND HOUR OF DEATH: 1-8-67 8:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: CALVERT Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): SUNDERLAND 54-00
D. STREET ADDRESS (If rural, give location):

5. SEX: FEMALE
6. RACE: NEGROID
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 2-5-62
9. AGE (In years last birthday): 4
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: THEODORE BROOKS
14. MOTHER'S MAIDEN NAME: GOLDIE LONG
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: Sunderland - Md

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH: (A) 60% 2nd + 3rd degree burn DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 8 days
(B) DUE TO —
(C)

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pneumonia

CERTIFICATION APPROVED BY M.D. CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☒
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Sunderland, Maryland 54-00
21D. TIME OF INJURY (APROX.) (Month) (Day) (Year) (Hour): 12-31-66 7:45 AM
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☒
21F. HOW DID INJURY OCCUR?: Clothes caught fire from wood stove

22. I certify that (I) (this hospital) attended the deceased from 12-31 1966 to 12-8 1967, that (I) (we) last saw the deceased alive on 12-8 1967 and that in (my) (our) opinion death accurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: L. C. Parks M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-8-67
23C. PHYSICIAN'S NAME (Type): Leon C. Parks M.D.
23D. ADDRESS: Johns Hopkins Hospital Balt Md.

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 1-10-67
24C. NAME of CEMETERY or CREMATORY: Youngs C.C.
24D. LOCATION (City, town, or county) (State): Huntingtown- Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Stanley M.D.
25C. FUNERAL DIRECTOR: Pinkney & Sewell Prince ADDRESS: Fred. Md

VS 150-REV. 1/1/65

N 946

T-61.6

BIRTH NO. 67 0350

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0350

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): VERA E. TRAVERS

2. DATE AND HOUR OF DEATH: January 8, 1967 | 6:05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21216 16-06
D. STREET ADDRESS (If rural, give location): 614 Claymont Avenue

5. SEX: FEMALE
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 8/9/83
9. AGE (In years last birthday): 83
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS
10B. KIND OF BUSINESS OR INDUSTRY: FOR SELF
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel C. Travers
14. MOTHER'S MAIDEN NAME: Susan Gould

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Chart
ADDRESS

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronchopneumonia
DUE TO

(B)
DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Metastatic carcinoma, liver + lung, primary?

19A. DATE OF OPERATION
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-23 1966 to 1-8 1967, that (I) (we) last saw the deceased alive on 8 January 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 8 January 1967

23C. PHYSICIAN'S NAME (Type): SAUL BRAZIN M.D.
23D. ADDRESS: Bon Secours Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/11/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: H. W. Mears & Son
ADDRESS: 805 N. Calvert St.

VS 150-REV. 11/1/65

M-655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0351 Registered No. 67 0351

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARTHA PARKS MERRYMAN

2. DATE AND HOUR OF DEATH: January 7, 1967 7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 SILVER CROSS HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): TOWSON 53-00
D. STREET ADDRESS (If rural, give location): 413 GEORGIA COURT

5. SEX: ~~WHITE~~ FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: JUNE 26, 1881
9. AGE (In years last birthday): 85
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SAMUEL E. PARKS
14. MOTHER'S MAIDEN NAME: MARTHA LEE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 216-48-3152
17. INFORMANT: FAMILY RECORDS
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): 334 X
(A) Arteriosclerotic Cerebro-vascular Disease
INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
(B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Parkinson's Disease — unknown

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 1965 to January 1967, that (I) (~~we~~) last saw the deceased alive on January 4 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Leo J. Gaver M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/7/67
23C. PHYSICIAN'S NAME (Type): LEO J. GAVER M.D.
23D. ADDRESS: 1 Mallow Hill Ave Baltimore, Md

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN. 10, 1967
24C. NAME of CEMETERY or CREMATORY: PROSPECT HILL CEM.
24D. LOCATION (City, town, or county) (State): TOWSON, MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Walter F. Burns
ADDRESS: Towson, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-041

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0352

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0352

1. NAME OF DECEASED (Type or Print): Francis Dano Jackley

2. DATE AND HOUR OF DEATH: January 10, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3902 Cloverhill Road

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 3902 Cloverhill Road

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Jan. 22, 1900
9. AGE (In years last birthday): 66
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architect
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Jackley
14. MOTHER'S MAIDEN NAME: Nellie Dietrich

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 212-10-0825
17. INFORMANT: Mrs. Jean D. Jackley
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Congestive heart failure — 20 hours
DUE TO
(B) Acute pulmonary edema — 10 + years
DUE TO
(C) Coronary artery disease
Atherosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1957 19 to Jan 10th 1967, that (I) (~~we~~) last saw the deceased alive on 10 Jan 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Louis P. Hamburger Jr. M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Jan 11, 1967
23C. PHYSICIAN'S NAME (Type): Dr. Louis P. Hamburger M.D.
23D. ADDRESS: 1001 St. Paul St. Baltimore, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-67
24C. NAME of CEMETERY or CREMATORY: Friends Burial Ground
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Mitchell-Wiedefeld Home, Inc.
ADDRESS: 6500 York Road Baltimore, Md. 21212

VS 150-REV. 1/1/65

K-624

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0353 Registered No. 67 0353

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Maynard Eugene Kirkland, Sr.

2. DATE AND HOUR OF DEATH: Jan. 10, 1967 4:00 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): OO 1111 Park Avenue Baltimore, Md. 21201

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: 21201
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 1111 Park Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: Feb. 23, 1892
9. AGE (In years last birthday): 74
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Appliances
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Kirkland
14. MOTHER'S MAIDEN NAME: Olivia Harman
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): War I
16. SOCIAL SECURITY NO.: 213-10-8983
17. INFORMANT: Bertha M. Kirkland (Wife) ADDRESS: Same

MEDICAL CERTIFICATION

1B. 153 X 1260 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma Head of Pancreas with metastasis — 8 mos.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 14 yrs

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(this hospital)~~ attended the deceased from Aug 1953 to Jan 1967, that (I) ~~(we)~~ last saw the deceased alive on Jan. 6 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ ~~(did)~~ (did not) view the body after death.

23A. SIGNATURE: Com. H. Kammer Jr. M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): Wm. H Kammer, Jr. M.D.
23D. ADDRESS: 6011 York Road Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan 13/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Eugenia K. Seitz ADDRESS: 5209 York Road Seitz Funeral Home Balto. Md. 21212

VS 150-REV. 1/1/65

M-63

BIRTH NO. 67 0354

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0354

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Martindale, Edgar A. Jr.

2. DATE AND HOUR OF DEATH: 1-8-1967 5;00P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St/ Agnes Hospital

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Catonsville Manor 53-00
D. STREET ADDRESS (If rural, give location): 5917 Central Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 12-13-19XX 09
9. AGE (In years last birthday): 57
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookbinder
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edgar A. Martindale, Sr.
14. MOTHER'S MAIDEN NAME: Semone

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-03-8428
17. INFORMANT: Mrs. Carrie E. Martindale, ADDRESS: 5917 Central Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Coronary Occlusion — Last attack 2 hours
DUE TO
(B) Coronary Heart
DUE TO
(C) Disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): —
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1963 19 to Jan 8 1967, that (I) (we) last saw the deceased alive on Jan 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Paul Byerly M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 9/10/67
23C. PHYSICIAN'S NAME (Type): Dr. Paul W. Byerly M.D.
23D. ADDRESS: 5820 York Road, Baltimore, Maryland

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-12-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farkuna
25C. FUNERAL DIRECTOR: Howard H. Hubbard, ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

C-352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0355 Registered No. 67 0355

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WILLIAM F. CUDNIK

2. DATE AND HOUR OF DEATH: January 10, 1967 | 5.00 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 3155 Lyndale Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 3155 Lyndale Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	11/14/04	62		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Baker	Retail Bakery	New Jersey	U.S.A.

13. FATHER'S NAME: Frank Cudnik

14. MOTHER'S MAIDEN NAME: Elizabeth Michalak

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	217-01-2056	Mrs. Sophia Cudnik	3155 Lyndale Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

163X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cerebral Metastasis — 2 mos
DUE TO
(B) Carcinoma of the Lung — 7 mo.
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 19 66 to 1/9/67 19 67, that (I) (we) last saw the deceased alive on 1/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: G. Richards Jr. M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type): George J. Richards Jr M.D.

23D. ADDRESS: Greater Baltimore Med. Center

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/13/67

24C. NAME of CEMETERY or CREMATORY: St. Stanislaus

24D. LOCATION (City, ~~XXXXXXXXXX~~ (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR: M. F. SADOWSKI & SONS, 1808 EASTERN AVE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

1
B-632

BIRTH NO. 67 0356

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0356

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PERCY Klein BRITCHER

2. DATE AND HOUR PRONOUNCED DEAD: January 8, 1967 7:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-34
D. STREET ADDRESS (If rural, give location): 5846 Belair Road #6

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 3/8/05
9. AGE (In years last birthday): 61
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10B. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Britcher
14. MOTHER'S MAIDEN NAME: Louise Klein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Britcher, wife, above
ADDRESS

MEDICAL CERTIFICATION

18. 443X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/12/67
23C. NAME of CEMETERY or CREMATORY: Ebenezer Cemetery
23D. LOCATION (City, town, or county) (State): Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3331 Frems Lane #13

VS 151-REV. 1/1/65

H-2 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0357 Registered No. 67 0357

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HAAS Joseph Harry

2. DATE AND HOUR OF DEATH: 1-10-67 | 2 20 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): North Charles General Hospital 49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21237
D. STREET ADDRESS (If rural, give location): 421 S. Madeira Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Cauc.	Married	7-18-08	58 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Eastern Stainless Steel Corp.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Haas, John
14. MOTHER'S MAIDEN NAME: Pearl Gray

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-01-9130
17. INFORMANT: Mildred Haas (wife) ADDRESS: Same as Above

MEDICAL CERTIFICATION

18. 181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinoma of the Bladder
DUE TO Metastasis to colon

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12-11-66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Colon
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~This hospital~~) attended the deceased from 11-17 1966 to 1/10/ 1967, that (I) (~~we~~) last saw the deceased alive on 1-10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alejandro Martoyo M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): DR. M. JAWORSKI M.D.
23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/13/67	Oak Lawn Cemetery	Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Fahey
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc. ADDRESS: 6331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-166

67 0358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0358

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): AQUILLA SCHAFER

2. DATE AND HOUR OF DEATH: 1-9-67 | 12 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 MELCHOR NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-06

D. STREET ADDRESS (If rural, give location): 2808 Hamilton Avenue #14

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
F.	W.	widowed	Aug. 1, 1893	73 yrs.		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Ritz Enterprise	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Ernst Lenk

14. MOTHER'S MAIDEN NAME: Ida A. Voigt

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-26-7098

17. INFORMANT: Felix Schafer, son, 2808 Hamilton Ave.

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 795-X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Senile emphysema

DUE TO

(C) Kyphosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-30- 1966 to 1-9- 1967, that (I) (we) last saw the deceased alive on 1-9- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cesar Valle Cavero M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-10-67

23C. PHYSICIAN'S NAME (Type): CESAR VALLE CAVERO M.D.

23D. ADDRESS: 3629 Liberty Rd

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/12/67	Baltimore Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 12 1967	Robert E. Fackenthal	Schimunek Funeral Home, Inc.	3331 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0359 Registered No. 67 0359

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anna M. Husted

2. DATE AND HOUR OF DEATH: January 11, 1967 | 11:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1917 E. Belvedere Ave.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

9-03

D. STREET ADDRESS (If rural, give location): 3708 Rexmere Rd.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single

8. DATE OF BIRTH: December 6, 1882.

9. AGE (In years last birthday): 84

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry T. Husted

14. MOTHER'S MAIDEN NAME: Anna E. Knoble

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-48-6035

17. INFORMANT: Mrs. Erck H. Heller, ADDRESS: 1917 Belvedere Ave.

MEDICAL CERTIFICATION

1B. 153.8

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Lobar pneumonia (R) — 1 week

DUE TO

(B) Carcinoma colon — 6 weeks

DUE TO

(C) post operative

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 1966 to 19..., that (I) (we) last saw the deceased alive on Jan 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Charles C. MacMinn M.D. Attending Phys. [X] Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: January 12, 1967

23C. PHYSICIAN'S NAME (Type): Charles C. MacMinn, M.D. M.D.

23D. ADDRESS: 2900 E. Baltimore St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/14/67

24C. NAME of CEMETERY or CREMATORY: Oaklawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-46

BIRTH NO. 67 0360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0360

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Virginia Allen

2. DATE AND HOUR OF DEATH: 1/10/67 6:20 PM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 811-J Street

5. SEX: Fe

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 9/11/1891

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Calverton, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Melvin Johnson

14. MOTHER'S MAIDEN NAME: Ada Louise Johnson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. James Allen ADDRESS: 811 J. Street

MEDICAL CERTIFICATION

1B. 290.2

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congestive Heart Failure — less than 1 day

DUE TO

(B) Severe Anemia — ?

DUE TO

(C) Possible Pernicious or megaloblastic Anemia

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA. ② ASCVD

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 10, 1967 to January 10, 1967, that (I) (we) last saw the deceased alive on January 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert C Blackmon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): Robert C. Blackmon M.D.

23D. ADDRESS: Lutheran Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/14-67

24C. NAME of CEMETERY or CREMATORY: Ebenezer Ch. Cemetery

24D. LOCATION (City, town, or county) (State): Midland Virginia

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967

25B. NAME OF REGISTRAR: Robert E. Fashion

25C. FUNERAL DIRECTOR: Motter Dyeff F.H.

ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0361 Registered No. 67 0361

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DORA JACKSON

2. DATE AND HOUR OF DEATH: 1/11/67 7 25 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSP. OF BALTIMORE, INC.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE S-02
D. STREET ADDRESS (If rural, give location): 1101 ORLEANS ST.

5. SEX: F
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 5/30/14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: SOUTHERN LIFE INS.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES WILLIS
14. MOTHER'S MAIDEN NAME: CECELIA MARKENS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: WALTER WILLIS — ADDRESS: 1142 N. CARROLLTON AVE

MEDICAL CERTIFICATION

1B. 171 XX 260X

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: CARCINOMA OF CERVIX & METASTASES — UNK.

(B) DUE TO:

(C):

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: DIABETES MELLITUS — UNK.

19A. DATE OF OPERATION: NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NONE
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 1/11/67 19 to 1/11/67 19, that I (we) last saw the deceased alive on 1/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: J. Brett Lazar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): J. BRETT LAZAR M.D.
23D. ADDRESS: SINAI HOSP. OF BALT. INC.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county): Arbutus (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 12 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Burton & Dysett F.H. — ADDRESS: 1701 Laurens St.

VS 150-REV. 1/1/65

W-261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 67 0362 Registered No. 67 0362

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): NELLIE K. Waterfield

2. DATE AND HOUR OF DEATH: 1/9/67 11:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 37 Mercy Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): EASTWOOD 53-00

D. STREET ADDRESS (If rural, give location): 7041 E. BALTIMORE ST. #21224,

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
FEMALE	WHITE	WIDOWED	OCT. 29, 1898	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED	HOUSE WORK	PENNSYLVANIA	U.S.A.

13. FATHER'S NAME: EMANUEL J. STREETT.

14. MOTHER'S MAIDEN NAME: FLORENCE HAMMOCK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 226-20-3299A

17. INFORMANT: GLADYS K. MASKELL ADDRESS: SAME.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subendocardial degeneration — 24 hrs.

DUE TO

(B) ASCVD.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cor pulmonale
Chronic pulmonary emphysema

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None	—	yes	yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 1/9 1967 to 1/9 1967, that (I) (we) last saw the deceased alive on 1/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Philip B. Dvoskin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): PHILIP B. DVOSKIN M.D.

23D. ADDRESS: MERCY HOSP., BALTO., MD.

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	1-14-67	BETHANY CEM.	CALLAO, VA.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 13 1967	R. C. E. Farley M.D.	Charles J. Feiler	6224 EASTERN AVE. BALTO., 21224, MD.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-436

BIRTH NO. 67 0363

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0363

FUNERAL DIRECTOR: IMPORTANT

This certificate must be c[illegible]ved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): WILT MR. EDWARD DEAN

2. DATE AND HOUR OF DEATH: 1-10-1967 1 45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MONTEBELLO STATE HOSPITAL
BALTIMORE. MD.
91

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE ESSEX 53-00
D. STREET ADDRESS (If rural, give location): 27 AVENAL ROAD

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-30-1915
9. AGE (In years last birthday): 51
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER (LABOR)
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: RUSSELL WILT
14. MOTHER'S MAIDEN NAME: EVA PROVINCE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 232-05-1407
17. INFORMANT: MRS. ROSALIE WILT (WIFE)
ADDRESS: SAME

MEDICAL CERTIFICATION

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) ARTERIOSCLEROTIC ARTERIAL OCCLUSIVE DISEASE. — INTERVAL BETWEEN ONSET AND DEATH: ABOUT 36 MONTHS

DUE TO

(B) GENERALIZED ADVANCED ARTERIOSCLEROTIC C-V. DISEASE — ? YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: (OCTOBER) 10, 1966
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: (OTHER HOSPITAL) THROMBOENDARTERECTOMY
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-3- 1967 to 1-10- 1967, that (I) (we) last saw the deceased alive on 1-10- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zin U. Park M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-10-1967
23C. PHYSICIAN'S NAME (Type): ZIN U. PARK M.D.
23D. ADDRESS: MONTEBELLO STATE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Belair Mem.
24D. LOCATION (City, town, or county) (State): Belair Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: J. B. Connally Sons
ADDRESS: 300 Mace

VS 150-REV. 1/1/65

P-155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BOOK NO. 67 0364 Registered No. 67 0361

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN PENNINGTON

2. DATE AND HOUR OF DEATH: 1-6-67 8 25 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Mont. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 8811 COLESVILLE RD. SILVER SPRING

D. STREET ADDRESS (If rural, give location): 8811 COLESVILLE RD MONTGOMERY CO. 65-00

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 07-08-02

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: JOHN HENRY PENNINGTON

14. MOTHER'S MAIDEN NAME: JULIA TOOKEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

MEDICAL CERTIFICATION

1B. 153.8 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Metastatic Carcinoma of Colon

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) ~~(This hospital)~~ attended the deceased from Jan 3, 1967 to Jan 6, 1967, that (I) ~~(we)~~ last saw the deceased alive on Jan 6, 1967 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: A P Weingeld M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Jan 6, 1967

23C. PHYSICIAN'S NAME (Type): A. P. WEINGELD M.D.

23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

ANATOMY BOARD OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify):

24B. DATE: 1/10/67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Fashyna

25C. FUNERAL DIRECTOR: O MORTUARY SERVICE - BCHD

ADDRESS:

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-52d

67-00353

BIRTH NO. 67 0365

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0365 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): BABY BOY THOMAS

2. DATE AND HOUR OF DEATH: 1-8-67. 11:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: none
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL, and give township): none 18-01
D. STREET ADDRESS (If rural, give location): 925 W. Franklin St.

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 1-8-67
9. AGE (In years last birthday): If Under 1 Yr. Months: Days: Hours: 12 Min.: 19

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: AGNES THOMAS.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chart #340538. ADDRESS:

MEDICAL CERTIFICATION

1B. 776 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) IMMATURITY — 12

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1-8 1967 to 1-8 1967, that ~~(I)~~ (we) last saw the deceased alive on 1-8 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Albert M. Gordon M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-8-67.
23C. PHYSICIAN'S NAME (Type): ALBERT M. GORDON M.D.
23D. ADDRESS: ANATOMY BOARD OF MARYLAND

24A. BURIAL CREMATION, REMOVAL (Specify):
24B. DATE: 1-10-67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: R. C. & E. Jackson
25C. FUNERAL DIRECTOR: O MORTUARY SERVICE - BCHD
ADDRESS

VS 150-REV. 1/1/65

D-56

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0366 Registered No. 67 0366

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) John DiMartino

2. DATE AND HOUR OF DEATH 1-12-67. 12 30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2226 Harford Road

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #18 9-08
D. STREET ADDRESS (If rural, give location) 2226 Harford Road

5. SEX Male
6. RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH March 19, 1885.
9. AGE (In years last birthday) 81
If Under 1 Yr. Months Days
If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman
10B. KIND OF BUSINESS OR INDUSTRY Shoe Shop
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph DiMartino
14. MOTHER'S MAIDEN NAME Josephine Cimino

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-34-3170
17. INFORMANT Mrs. Grace DiMartino
ADDRESS (Same)

MEDICAL CERTIFICATION

18. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary insufficiency
DUE TO
(B) Coronary arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY Charles [illegible] M.D. CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1947 to Jan 12 1967, that (I) (~~we~~) last saw the deceased alive on 1965 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE R Donald Jandorf M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED 1-12-67
23C. PHYSICIAN'S NAME (Type) R Donald Jandorf M.D.
23D. ADDRESS 6077 Harford Rd

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/16/67.
24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 13 1967
25B. NAME OF REGISTRAR Robert E. Farley M.D.
25C. FUNERAL DIRECTOR Leonard J. Huck, Inc. ADDRESS Balto. Md. 21214

VS 150-REV. 1/1/65.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-3210

BIRTH NO. 67 0367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0367

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) (Adolph) Adalph O. Goetz (Goetz)

2. DATE AND HOUR OF DEATH 1/12/67 12:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

48 Hosp Maryland General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto Md 21212

D. STREET ADDRESS (If rural, give location) 5822 Falkirk Rd.

5. SEX M

6. RACE W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W

8. DATE OF BIRTH 1/15/84

9. AGE (In years last birthday) 82

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter

10B. KIND OF BUSINESS OR INDUSTRY retired

11. BIRTHPLACE (State or foreign country) Balto, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Goetz

14. MOTHER'S MAIDEN NAME Minnie H Goetz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-01-6208

17. INFORMANT Miss Anna F. Goetz

ADDRESS (Same)

MEDICAL CERTIFICATION

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Bronchopneumonia

DUE TO Aspiration Pneumonia

(B) Arteriosclerotic heart disease

DUE TO

(C) Acute diverticulitis

Pneumothorax, left.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/3 1967 to 1/12 1967, that (I) (we) last saw the deceased alive on 1/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE Daniel Wilkerson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED 1/11/67

23C. PHYSICIAN'S NAME (Type) Daniel C. Wilkerson M.D.

23D. ADDRESS 421 Rogerter Ave.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/14/67.

24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 13 1967

25B. NAME OF REGISTRAR Robert E. Bailey, M.D.

25C. FUNERAL DIRECTOR Leonard J. Fuck, Inc.

ADDRESS Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-640

BIRTH NO. 67 0368

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0368

1. NAME OF DECEASED (Type or Print): Mae Ann Mary Saraullo (Saraullo)

2. DATE AND HOUR OF DEATH: January 12 1967 10.05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #34 27-07 D. STREET ADDRESS (If rural, give location): 2736 Kildare Drive

5. SEX: Female 6. RACE: Caucasian 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow 8. DATE OF BIRTH: Sept. 30 1901 9. AGE (In years last birthday): 65 If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (Housekeeper) 10B. KIND OF BUSINESS OR INDUSTRY: Church 11. BIRTHPLACE (State or foreign country): Louisianna 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Cylotta 14. MOTHER'S MAIDEN NAME: Geraldine Marino

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.: 214-01-1823 17. INFORMANT: Mrs. Rose Kruszynski ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 2001 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Lymphosarcoma — 4 months

DUE TO (B)

DUE TO (C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 28 1966 to Jan 12 1967, that (I) (we) last saw the deceased alive on Jan 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Joe T. Chandler M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: Jan. 12, 1967

23C. PHYSICIAN'S NAME (Type): JOE T. CHANDLER M.D. 23D. ADDRESS: THE UNION MEMORIAL HOSPITAL, Baltimore Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1/16/67. 24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Cemetery 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967 25B. NAME OF REGISTRAR: Robert E. Fahrney 25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0369 Registered No. 67 0369

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLA Foster

2. DATE AND HOUR OF DEATH: 1-7-67 | 11 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1216 N. CENTRAL AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 10-01
D. STREET ADDRESS (If rural, give location): 1216 N. CENTRAL AVE

5. SEX: F
6. RACE: C.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow
8. DATE OF BIRTH: 2-20-78
9. AGE (In years last birthday): 88 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO. Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John JENKINS
14. MOTHER'S MAIDEN NAME: JANE Bishop.

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JAMES V. KEENE | ADDRESS: 1216 N. CENTRAL AV

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic Heart Disease — ?

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec. 15 1966 to Jan. 1 1967, that (I) (we) last saw the deceased alive on Dec. 16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Bernard Harris Sr M.D. | Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): Bernard Harris Sr M.D.
23D. ADDRESS: 1202 N Carolina St

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/12/67
24C. NAME of CEMETERY or CREMATORY: MT. CALVARY
24D. LOCATION (City, town, or county) (State): A.A. COUNTY, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: Robert E. Farber M.D.
25C. FUNERAL DIRECTOR: Joseph L. Lockard | ADDRESS: 1304 N. Central Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released or Approved by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0370 — Registered No. 67 0370

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES HENRY BEITZELL

2. DATE AND HOUR OF DEATH: 1-6-67 4:30 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp. 48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: St. Mary's Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Avenue 68-00
D. STREET ADDRESS (If rural, give location):

5. SEX: Male — 6. RACE: White — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed — 8. DATE OF BIRTH: Sept. 13, 1873 — 9. AGE (In years last birthday): 93 — If Under 1 Yr. Months / Days — If Under 24 Hrs. Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Riverman & Farmer — 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Kilmarnock, Virginia — 12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Josiah Edward Beitzell — 14. MOTHER'S MAIDEN NAME: Mary Elizabeth Wesser

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): — (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: 215-38-2994 — 17. INFORMANT: Mary Alice B. McWilliams — ADDRESS: Clements, Md.

18. 422 I 7 E 904 — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic
DUE TO (B) Heart Dis.
DUE TO (C) Acute
Fract Rt Hip + Surg Repair

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY — CHIEF OR ASST. MEDICAL EXAMINER — M.D. — 2-23-67

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 1-4-67 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fx Rt Hip — 20A. AUTOPSY? (Yes or No): — — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☐ — 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.): Nursing Home — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Bolton Hill Nursing Home

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1-1-67 — 21E. INJURY OCCURRED: While At Work ☐ — Not While At Work ☑ — 21F. HOW DID INJURY OCCUR? Fall in Hip Being chased by patient.

22. I certify that ~~I~~ (this hospital) attended the deceased from 1-3 1967 to 1-6 1967, that ~~I~~ (we) last saw the deceased alive on 1-6 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: [signature] M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☑ — 23B. DATE SIGNED: 1-6-67

23C. PHYSICIAN'S NAME (Type): D. R. Boyd M.D. — 23D. ADDRESS: Maryland Gen Hosp

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 1-9-67 — 24C. NAME of CEMETERY or CREMATORY: Sacred Heart — 24D. LOCATION (City, town, or county) (State): Bushwood, St Marys Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967 — 25B. NAME OF REGISTRAR: Robert E. Fabian — 25C. FUNERAL DIRECTOR: W Clarke Mattingly — ADDRESS: Leonardtown Md.

VS 150-REV. 1/1/65

N 8200

2-4 10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0371 Registered No. 67 0371

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HARRY ZULAUF

2. DATE AND HOUR OF DEATH: 1-11-1967 | 6:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 49 NORTH CHARLES GEN. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 7814 BAGLEY AVE. 34

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 8-16-1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: B + O. RR Co.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Zulauf

14. MOTHER'S MAIDEN NAME: ANNIE WALLACE

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: A 705-03-9019

17. INFORMANT: NORTH CHARLES GEN. HOSP. CHART. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASPIRATION PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B) CEREBRO-VASCULAR ACCIDENT — 10 days.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-4 1967 to 1-11 1967, that (I) (we) last saw the deceased alive on 1-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dr. Juan F. Oleman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-11-1967

23C. PHYSICIAN'S NAME (Type): DR. SHELDON GOLDGEIER M.D.

23D. ADDRESS: 848 W. 36th St. BALTIMORE, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-14-1967

24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery

24D. LOCATION (City, town, or county) (State): Parkwood Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Faiby, M.D.

25C. FUNERAL DIRECTOR: Dassahn & Home

ADDRESS: 7401 Belair Rd

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0372 Registered No. 67 0372

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): DORA SINCLAIR

2. DATE AND HOUR OF DEATH: 1/11/67 3 43 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSP. OF BALTIMORE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-44
D. STREET ADDRESS (If rural, give location): 3512 E. Fayette St #24

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 9/13/08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Line Operator
10B. KIND OF BUSINESS OR INDUSTRY: Paul Jones Distillers
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Sautters
14. MOTHER'S MAIDEN NAME: Fannie Albers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 214-26-8494
17. INFORMANT: Mrs. Evelyn Moore
ADDRESS: 5122 Henry Avenue-21206

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 453.9

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Cardio-Pulmonary Failure
DUE TO
(B) Poss. Massive Pneumonia
DUE TO
(C) Poss. Pulmonary Embolism.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1/5/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bypass vascular disease
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/30/ 1966 to 1/11/ 1967, that ~~(I)~~ (we) last saw the deceased alive on 1/11/ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Francisco D. Salado, Jr. M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: John C. Miller Inc
ADDRESS: 6415 Belair Rd.-21206

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-261

BIRTH NO. 67 0373

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0373

1. NAME OF DECEASED (Type or Print): Mary E. Tucker

2. DATE AND HOUR OF DEATH: 1/11/67 8:40AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital, Baltimore, Md. 21229

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 25-52

D. STREET ADDRESS (If rural, give location): 1723 Letitia Ave.

5. SEX: f

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12/16/1894

9. AGE (In years last birthday): ~~XX~~ ~~XX~~ 72

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Luther Franklin

14. MOTHER'S MAIDEN NAME: Amelia Grimes

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 215-34-6062

17. INFORMANT: Mrs. Frances I. Pickett, ADDRESS: 3681 McTavish Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 465X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) massive pulmonary embolus. —

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/11/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-14-1967

24C. NAME of CEMETERY or CREMATORY: Taylorsville Meth. Cemetery Church

24D. LOCATION (City, town, or county) (State): Taylorsville, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Kelley M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard, ADDRESS: 4107 Wilkens Avenue 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-25

Annapolis, Md.

BIRTH NO. 67 0374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0374

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROBERT L. JACKSON

2. DATE AND HOUR OF DEATH: 1-10-67 10:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY: A.A.C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): GAMBRILLS

D. STREET ADDRESS (If rural, give location): 52-00

5. SEX: M.

6. RACE: W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 10-30-66

9. AGE (In years last birthday): 2 1/2 mo.

If Under 1 Yr. Months: 2 Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HERMAN JACKSON

14. MOTHER'S MAIDEN NAME: RUBY CORR

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

ADDRESS: Baltimore, Md.

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) 1) Pulmonary Hemorrhage — ?
DUE TO 2) Thrombocytopenia

(B) 3) Cerebral Edema — ?
DUE TO 4) Hypoalbuminemia

(C) 5) Congenital stenosis of Jejunum — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/9 1967 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Robert R. Holtzman M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: Hillcrest Cemetery

24D. LOCATION (City, town, or county) (State): Annapolis, Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: Beverley E. Hopping, Hopping Funeral Home

ADDRESS: Beverley E. Hopping, Annapolis, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J 525

BIRTH NO. 67 0375

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0375

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Pearl Johnson

2. DATE AND HOUR OF DEATH: 1/11/67 10:30 a M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital, 601 North Broadway, Baltimore, Maryland 21205

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3303 Paton Avenue

27-17

5. SEX: F
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: 12/23/05
9. AGE (In years last birthday): 61 yrs.
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henderson, Wray
14. MOTHER'S MAIDEN NAME: Mahalla

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-38-1425
17. INFORMANT: CARRIE RICHMOND ADDRESS: 5211 DEMMORE AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of Endometrium — INTERVAL BETWEEN ONSET AND DEATH: 15 mos.
DUE TO
(B) Ascites, Cerevisiae — 1 mo
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10/16/65
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Adenoca of Endometrium
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct 12 1965 to Jan 11 1967, that (I) (we) last saw the deceased alive on Jan 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold T. Elberfeld M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): Dr. Harold T. Elberfeld M.D.
23D. ADDRESS: The Johns Hopkins Hospital 601 Broadway

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: CARVER MEMORIAL
24D. LOCATION (City, town, or county) (State): LAUREL Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: Robert E. Fahrner
25C. FUNERAL DIRECTOR: JOSEPH KNIGHT ADDRESS: 1639 N. BROADWAY

VS 150-REV. 1/1/65

K-650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0376 Registered No. 67 0376

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): KEARNEY ANNIE L.

2. DATE AND HOUR OF DEATH: 1-10-1967 9.30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LUTHERAN HOSP. of MARYLAND

46

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-09

D. STREET ADDRESS (If rural, give location): 4610 CARLISLE AVE.

5. SEX: FEMALE

6. RACE: NEGRO

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 7-25-94

9. AGE (In years last birthday): 73

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): NC

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM AUSTIN

14. MOTHER'S MAIDEN NAME: ANNAH JOHNSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 241-56-0722

17. INFORMANT: RUTH CLANTON ADDRESS: 1722 E. LANVALE ST

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) UREMIA & COMA

DUE TO

(B) HACVD.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-8- 1967 to 1-10- 1967, that (I) (we) last saw the deceased alive on 1-10- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: José R. Sturich M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: January 10 1967

23C. PHYSICIAN'S NAME (Type): JOSÉ R. STURICH M.D.

23D. ADDRESS: 2519 Gittelsohn Dr. BALTO. 7

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-15-67

24C. NAME of CEMETERY or CREMATORY:

24D. LOCATION (City, town, or county) (State): WARRENGTON N.C.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Joseph Kraut ADDRESS: 1639 N Broadway

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-2130

67 0377

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Louise Faust

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 8:10 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05

D. STREET ADDRESS (If rural, give location): 423 E. North Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	colored	Widow	4-19-10	56		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	housewife	Blackstone, Va.	U.S.A.

13. FATHER'S NAME: James Rice

14. MOTHER'S MAIDEN NAME: Hender ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 219-28-4991

17. INFORMANT: Mrs. Florence Ride

ADDRESS: 1403 Ensor St. 21202

MEDICAL CERTIFICATION

18. 443X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic and hypertensive cardio-vascular disease

~~DUE TO~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		no	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Werner U. Spitz M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-14-67	Mt. Calvary Cemetery	A.A. Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 13 1967	Robert E. Fadeyev M.D.	Marshall W. Jones, Jr.	1735 Harford Ave.

0376

VS 151-REV. 1/1/65

C-462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0378 Registered No. 67 0378

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JULIA CLARK

2. DATE AND HOUR OF DEATH: 1-11-67 | 7 53 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-01
D. STREET ADDRESS (If rural, give location): 507 E. 27th St

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	4-6-05	61		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Almore Norman
14. MOTHER'S MAIDEN NAME: Annie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-18-9817
17. INFORMANT: Patient Chart
ADDRESS:

MEDICAL CERTIFICATION

1B. 4201

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute Myocardial Infarction — 45 min
DUE TO
(B) Coronary Vascular disease — 14 days
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-28 19 66 to 1-11 19 67, that (I) (we) last saw the deceased alive on 1-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John R Vaughn Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-11-67
23C. PHYSICIAN'S NAME (Type): JOHN R. VAUGHN, JR M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-14-67	Mt. Calvary Cemetery	A.A. Co. Maryland

25A. DATE REC'D BY HEALTH DEPT. JAN 13 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Marshall W. Jones, Jr. ADDRESS: 1735 Harford Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

R-231

67 0379

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0379

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Margaret Richter

2. DATE AND HOUR OF DEATH: Jan 11, 1967 | 830 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

1725 Gorsuch Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-07

D. STREET ADDRESS (If rural, give location): 1725 Gorsuch Ave

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: Jan 3, 1884

9. AGE (In years last birthday): 83

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Faul

14. MOTHER'S MAIDEN NAME: Caroline Ackerman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: William L Richter — ADDRESS: 1725 Gorsuch Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from November 1966 to Jan 11 1967, that (I) (~~we~~) last saw the deceased alive on Jan 11 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~didn't~~) view the body after death.

23A. SIGNATURE: William H. Fusting M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-13-67

23C. PHYSICIAN'S NAME (Type): William H. Fusting M.D.

23D. ADDRESS: 4230 Loch Raven Blvd

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/14/67

24C. NAME of CEMETERY or CREMATORY: Jerusalem Cemetery

24D. LOCATION (City, town, or county) (State): 4600 Belair Rd Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Fairbanks

25C. FUNERAL DIRECTOR: J. Mitchell Jenkins — ADDRESS: 2713 Kirk Ave.

VS 150-REV. 1/1/65

P-6361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0380 Registered No. 67 0380

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THURMAN ROBERT PORTER

2. DATE AND HOUR OF DEATH: 1/8/67 9:10 PM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 38 UNIV. HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 14-03
D. STREET ADDRESS (If rural, give location): 555 ROBERT STREET

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	N	W	6/5/97	69				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
6	RETIRED	VIRGINIA	USA

13. FATHER'S NAME: RICE PORTER

14. MOTHER'S MAIDEN NAME: ANNIE BRADLEY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ? ADDRESS

MEDICAL CERTIFICATION

1B. 154X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Adeno Carcinoma of
DUE TO Recto Sigmoid c̄ metastasis
(B) to liver and brain
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/6/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: adeno Ca Sigmoid

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/23/66 19 to 1/8/66 19, that (I) (we) last saw the deceased alive on 1/8/66 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stuart L Fine M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/8/67

23C. PHYSICIAN'S NAME (Type): STUART L. FINE M.D.

23D. ADDRESS: UNIV. HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/13/67	Mt Calvary Cemetry	A A County Md

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 13 1967	Robert E. Fahey	Adolphus Halstead	1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-152

BIRTH NO. 67 0381

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0381

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GILDA ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD: January 8, 1967 4:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 2407 Lakeview Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 2407 Lakeview Avenue

5. SEX: Female
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 11/26/46
9. AGE (In years last birthday): 20
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Herbert Rogers
14. MOTHER'S MAIDEN NAME: Claudine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Herbert Rogers
ADDRESS: 1805 N Broadway

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E981X

(A) Gunshot Wound of Chest
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2407 Lakeview Avenue

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1 8 '67 4:22A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Was shot in chest

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/15/67
23C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry
23D. LOCATION (City, town, or county) (State): Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
24B. NAME OF REGISTRAR: Robert E. Falkenhan
24C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W Nort Ave

VS 151-REV. 1/1/65

N8 23 967 0 0 0 0 3 8 0

W-345

BIRTH NO. 67 0382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0382

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WOODLAND, Samuel Carlisle

2. DATE AND HOUR OF DEATH: 1-11-67 | 10.40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: 27-17
C. CITY OR TOWN (If outside city limits, write RURAL and give township): 4.900 Greenspring Ave.
D. STREET ADDRESS (If rural, give location): Baltimore MD 21209

5. SEX: M
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1/18/1892
9. AGE (In years last birthday): 74
If Under 1 Yr. Months | Days | (If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: INTERSTATE CIDER & VINEGAR CO.
11. BIRTHPLACE (State or foreign country): M.D
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Samuel H. Woodland
14. MOTHER'S MAIDEN NAME: Ellen Burneston

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES
(If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 219-05-9021
17. INFORMANT: CARLISLE WOODLAND
ADDRESS: 3505 Frankford Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 1B. 177 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of Prostate — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic Bronchitis & Emphysema

19A. DATE OF OPERATION: 12-31-66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Memory retention
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-26 1966 to 1-11 1967, that (I) (we) last saw the deceased alive on 1-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Felix J. Martin M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-11-67
23C. PHYSICIAN'S NAME (Type): FELIX J. MARTIN, M.D.
23D. ADDRESS: The Union Memorial Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Woodlawn, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: R. [illegible]
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co.
ADDRESS: 4905 York Rd. Baltimore 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-416

BIRTH NO. 67 0383

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0383

1. NAME OF DECEASED (Type or Print): MARY VIRGINIA ALBERT

2. DATE AND HOUR OF DEATH: Jan 12, 1967 | 2:25 a. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: Jenkins Memorial Hospital

(If not in hospital or institution, give street address or location): 1000 S. Caton Ave. Baltimore, Md. 21229

91

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN: Baltimore 21201 (If outside city limits, write RURAL and give township) 11-01

D. STREET ADDRESS (If rural, give location): Mt Royal Apts-Mt Royal & Calvert

5. SEX	6. RACE	7. MARITAL STATUS (NEVER MARRIED, WIDOWED, DIVORCED)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
F	W	Widowed	7-20-1881	85				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Artist	Needlework & Art	Baltimore	U S A

13. FATHER'S NAME: Irvin Albert

14. MOTHER'S MAIDEN NAME: Charlotte R. Raborg

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-46-3637

17. INFORMANT: M. Kohler-Medical Records -Jenkins Mem'l

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 450.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Gen. arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(B) Septicemia, infected

DUE TO

(C) Bed sores

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JUNE 1966 to JAN 1967, that (I) (we) last saw the deceased alive on 1-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Manuel J. Rodriguez M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-12-67

23C. PHYSICIAN'S NAME (Type): Manuel J. Rodriguez M.D.

23D. ADDRESS: Linden & S.W. Boulevard-Arbutus

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	1-14-67	New Cathedral	Baltimore	Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: H. J. Jenkins & Sons Co.

ADDRESS: 4905 York Rd, Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-410 1

BIRTH NO. 67 0384

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0384

1. NAME OF DECEASED (Type or Print): Clapp, Elizabeth F.

2. DATE AND HOUR OF DEATH: 1/11/67 - 6:20 PM. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 44 Union Memorial

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12 53-00
D. STREET ADDRESS (If rural, give location): Montrose Ave - Woodbrook

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 10/12/77
9. AGE (In years last birthday): 89
If Under 1 Yr. Months: 3 Days: Hours: If Under 24 Hrs. Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: ~~own~~ home
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nelson Johnson
14. MOTHER'S MAIDEN NAME: Agnes C. Hare

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-52-4350
17. INFORMANT: Harvey Rowland Clapp Jr. ADDRESS: Above

MEDICAL CERTIFICATION

1B. 520.21

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ~~Acute Abdomen~~ — ~~23 hrs~~

DUE TO

(B) ~~Acute~~

DUE TO Acute infarction of intestine

(C) due to adhesions band.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/10 1967 to 1/11 1967, that ~~(I)~~ (we) last saw the deceased alive on 1/11 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: D. S. Schwartz M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67

23C. PHYSICIAN'S NAME (Type): DR. DAVID S. SCHWARTZ M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-13-67
24C. NAME of CEMETERY or CREMATORY: West Nottingham
24D. LOCATION (City, town, or county) (State): Colora Cecil Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: R. E. Faber M.D.
25C. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. ADDRESS: 4905 York Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-325

BIRTH NO. 67 0385

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0385

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES WATSON

2. DATE AND HOUR PRONOUNCED DEAD: January 11, 1967 11:15 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1615 Ashland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 400 E. 22nd Street

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4/7/1897
9. AGE (In years last birthday): 69
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Range Operator
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: MARY WATSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 244 09 3278
17. INFORMANT: CHARITY Chester
ADDRESS: 3647 Belton Drive

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I B. 422.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/11/67

23A. BURIAL CREMATION, REMOVAL (Specify): Removal
23B. DATE: 1/14/67
23C. NAME of CEMETERY or CREMATORY: Springfield Baptist
23D. LOCATION (City, town, or county) (State): Weldon, N.C.

24A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
24B. NAME OF REGISTRAR: Robert E. Fairbanks
24C. FUNERAL DIRECTOR: Joseph L. Rocks Jr.
ADDRESS: 1304 N. Central Ave

VS 151-REV. 1/1/65

M-324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0386 Registered No. 67 0386

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES MITCHELL

2. DATE AND HOUR OF DEATH: 1-11-67 | 3:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTIMORE 42 BELVEDERE AT GREENSPRING

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MARYLAND
B. COUNTY: 20-05
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 23
D. STREET ADDRESS (If rural, give location): 301 MILLINGTON AVE

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 4-5-93
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ELDEE MITCHELL
14. MOTHER'S MAIDEN NAME: GEORGIANA

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 218-01-9307
17. INFORMANT: Charles K. Mitchell
ADDRESS: 411 Old York Rd. #18

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 177X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Metastasis — 12 month
DUE TO
(B) Ca of Prostate
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-21 19 64 to 1-11 19 67, that (I) (we) last saw the deceased alive on 1-11 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Emil E. Venturanza M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-11-67
23C. PHYSICIAN'S NAME (Type): VENTURANZA M.D.
23D. ADDRESS: SINAI HOSPITAL OF BALTIMORE

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-1967
24C. NAME of CEMETERY or CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: Rice B. E. Fackenthal
25C. FUNERAL DIRECTOR: Ellsworth Umbert
ADDRESS: 4600 Liberty Hghts. Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

9-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0387 Registered No. 67 0387

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN QUILL

2. DATE AND HOUR OF DEATH: Jan. 11 1967 | 12:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 36 Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 16-03
D. STREET ADDRESS (If rural, give location): 625 N. Mount ST

5. SEX: M
6. RACE: C
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): (WIDOWED circled)
8. DATE OF BIRTH: 12/8/99
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218079578
17. INFORMANT: Ellen Cooper (Mrs.) ADDRESS: 625 Mount St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.0

(A) Acute pulmonary edema

DUE TO

(B) ASHD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 11 19 67 to Jan 11 19 66, that (I) (we) last saw the deceased alive on Jan 11 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R S Magno M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): RAYMUNDO S. MAGNO M.D.
23D. ADDRESS: Franklin Square Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967
25B. NAME OF REGISTRAR: Vickers E. Talley M.D.
25C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/6

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0388 Registered No. 67 0388 C

~~M.E. CASE NO.~~ 67-00183

1. NAME OF DECEASED (Type or Print): BISHOFF (Baby Girl)

2. DATE AND HOUR OF DEATH: 1/6/67 4:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md B. COUNTY: Balto
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Balto 21-20
D. STREET ADDRESS (If rural, give location): Sinai Hosp. 3900 STRATHMORE AVE

5. SEX: F 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 8. DATE OF BIRTH: 1/4/67 9. AGE (In years last birthday): 2 days If Under 1 Yr.: Months Days (2) Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Sinai Hosp 12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: MARK L. BISHOFF 14. MOTHER'S MAIDEN NAME: Barbara ~~[illegible]~~ LDA NAMKEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service): — 16. SOCIAL SECURITY NO.: none 17. INFORMANT: Chart ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) ? Agenesis of (R) Lung — Congenital

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/5/67 19 to 1/6/67 19, that (I) (we) last saw the deceased alive on 1/6/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 1/6/67

23C. PHYSICIAN'S NAME (Type): Anthony B. Hone M.D. 23D. ADDRESS: Sinai Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1-9-67 24C. NAME of CEMETERY or CREMATORY: Geo. Washington Cemetery, Inc. 24D. LOCATION (City, town, or county) (State): Hyattsville, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 13 1967 25B. NAME OF REGISTRAR: [illegible] 25C. FUNERAL DIRECTOR: Goldberg Funeral Home ADDRESS: 4217 9th St NW, D.C

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0389 Registered No. 67 0389

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WALTER M. WOZNIAK

2. DATE AND HOUR OF DEATH: January 10, 1967 | 9.30 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-01

D. STREET ADDRESS (If rural, give location): 1915 Bank Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Single	9/10/13	53		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Attendant	Gasoline Service Station	Maryland	U.S.A.

13. FATHER'S NAME: Walter Wozniak

14. MOTHER'S MAIDEN NAME: Martha Brzozowski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-	215-10-8381	Mrs. Martha Willine	615 Dorsey Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) Diabetes Mellitus — 6 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/23 1965 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Samuel Morrison M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/12/67

23C. PHYSICIAN'S NAME (Type): SAMUEL MORRISON M.D.

23D. ADDRESS: 11 E. Chase St Balto. Md 21202

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City or county) (State)
Burial	1/14/67	Holy Rosary	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Farkas M.D.	M.B. SADOWSKI & SONS	1808 EASTERN AVE

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0390 Registered No. 67 0390

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THOMAS L. RUCKLE, Jr.

2. DATE AND HOUR OF DEATH: 1/13/67 11:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-18

D. STREET ADDRESS (If rural, give location): 503 Tunbridge Road

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1902

9. AGE (In years last birthday): 64

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night-Master

10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City

11. BIRTHPLACE (State or foreign country): BALTO., MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas L. Ruckle, Sr.

14. MOTHER'S MAIDEN NAME: Margaret McGeeney ~~McGeeney~~

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 216-03-5354

17. INFORMANT: Sarah E. Ruckle (Wife) ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Massive M.I. — INTERVAL BETWEEN ONSET AND DEATH: 0-5 minutes

DUE TO

(B) E. Coli Septicemia — 5 days

DUE TO

(C) Cirrhosis, (?) Perforated G.B. w/abscess — 5 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/8 1967 to 1/13 1967, that (I) (we) last saw the deceased alive on 1/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Dwight N. Martin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/1967

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Eugenia K. Seitz ADDRESS: 5209 York Rd. Seitz Funeral Home Balto. Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-08-92 ED PL630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 67 0391 Registered No. 67 0391

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ETHER PERDUE

2. DATE AND HOUR OF DEATH: January 12, 1967 1:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
4940 Eastern Ave.
Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 7859 EAST BALTIMORE ST.

5. SEX: MALE
6. RACE: CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 4/18/99
9. AGE (In years last birthday): 67
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ballard
14. MOTHER'S MAIDEN NAME: Ida HARRIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): UNK (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 228-09-7351
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md. ADDRESS # 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock
DUE TO
(B) Dehydration
DUE TO
(C) Diarrhea and Malnutrition — 1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 12 1967 to January 12 1967, that (I) (~~we~~) last saw the deceased alive on January 12 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alan J. Barnes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: January 12, 1967
23C. PHYSICIAN'S NAME (Type): Alan J. Barnes M.D.
23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Balto Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Farber, M.D.
25C. FUNERAL DIRECTOR: J. H. Connelly Sons
ADDRESS: 300 Mace

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

3-36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0392 Registered No. 67 0392

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary Ellen Widerman

2. DATE AND HOUR OF DEATH: Jan 12, 1967 2;00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-18

D. STREET ADDRESS (If rural, give location): 3312 W. Belvedere Ave. 21215

42

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: Nov. 6, 1907

9. AGE (In years last birthday): 59

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis

14. MOTHER'S MAIDEN NAME: Charity Schwartz

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr Kenneth E. Widerman ADDRESS: 4416 Eldone Rd Balto. Md. 21229

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1.12.67

DUE TO

(B) Diabetes — 2 years

DUE TO

(C) Hypertension — 2 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — —

19A. DATE OF OPERATION: None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: none

20A. AUTOPSY? (Yes or No): none

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? none

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): none

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): none

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): none

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? none

22. I certify that (I) (this hospital) attended the deceased from Jan 1 1965 to Jan 12 1967, that (I) (we) last saw the deceased alive on Jan 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Milton E Lowman M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): Milton E. Lowman M.D.

23D. ADDRESS: 4843 Park Heights Ave. Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/14/67

24C. NAME of CEMETERY or ~~CREMATORY~~: Lorraine Park

24D. LOCATION (City, town, or county) (State): 5608 Dogwood Rd Balto.7 Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Farley, M.D.

25C. FUNERAL DIRECTOR: Loring Byers ADDRESS: 828 Liberty Road Randallstown Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

E-631

67 0393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0393

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ~~JENNIE RICHMOND ERDMAN~~ Jennie Erdman

2. DATE AND HOUR OF DEATH: 1-14-67 | 7 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1802 Chilton St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township): 9-06

D. STREET ADDRESS (If rural, give location): 1802 Chilton St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
female	white	widowed	6/3/1882	84		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker	----	Ireland	USA

13. FATHER'S NAME: Daniel Richmond

14. MOTHER'S MAIDEN NAME: Karis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
---	---	220-44-2826	Mr. Richmond S. Erdman	(Son)

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery dis. — INTERVAL BETWEEN ONSET AND DEATH: 5 mos

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension — 40 years

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1961 to Jan. 14, 1967, that (I) (~~we~~) last saw the deceased alive on Dec. 19, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: R Donald Jandorf M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-14-67

23C. PHYSICIAN'S NAME (Type): R Donald Jandorf M.D.

23D. ADDRESS: 6077 Harford Rd

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/17/67	Greenmount	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Fisher, M.D.	Mitchell-Wiedefeld Home	6500 York Rd Balto. Md. 21212

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-5-23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0394 Registered No. 67 0394

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): EVA WEINSTEIN

2. DATE AND HOUR OF DEATH: JAN 10, 1967 | 10 a P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Belvedere Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-15

D. STREET ADDRESS (If rural, give location): 2208 Arden Road #9

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	White	Married		77		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	At Home	Russia	USA

13. FATHER'S NAME: Abraham Aleskowitz

14. MOTHER'S MAIDEN NAME: Mary ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		No	Mr. Jacob Weinstein	2208 Arden Road #9

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
416 X	(A) Congestive Heart Failure	6 weeks
	DUE TO (B) Rheum C V D	years
	DUE TO (C) Pneumonia-bronchial	

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 1966 to Jan 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Louis Goodman M.D. — M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): Dr. Louis Goodman M.D.

23D. ADDRESS: 225 Medical Arts Building

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/12/67	Beth El	New Haven, Connecticut

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: R. L. E. Taylor M.D.

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc. ADDRESS: 6010 Reist. Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

41-57-53TN

612-73

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0395

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0395

1. NAME OF DECEASED (Type or Print): McParlan, Frank IGNATIUS

2. DATE AND HOUR OF DEATH: 1/11/67 | 100 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY: BALTIMORE Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE COUNTY 53-00

D. STREET ADDRESS (If rural, give location): 1941 DUNDALK AVENUE 21222

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE

8. DATE OF BIRTH: 1-19-87

9. AGE (In years last birthday): 79

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PANITOR

10B. KIND OF BUSINESS OR INDUSTRY: RADIO CITY MUSIC HALL

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES MC PARLAN

14. MOTHER'S MAIDEN NAME: MARY ROSE MURPHY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 120-16-5643

17. INFORMANT: BCH: RECORDS

ADDRESS: 4940 EASTERN AVE. BALTO. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest

DUE TO

(B) Congestive Heart failure

DUE TO

(C) Senile emphysema

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: pneumonia, acidosis

19A. DATE OF OPERATION: 1/7/67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Bowel infarction

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/6/ 1967 to 1/11/ 1967, that ~~(I)~~ (we) last saw the deceased alive on 1/11 1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Carl Winterstein M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/11/67

23C. PHYSICIAN'S NAME (Type): DR. CARL WINTERSTEIN M.D.

23D. ADDRESS: 4940 EASTERN AVENUE Baltimore City Hospitals; Balto, Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/14/67

24C. NAME of CEMETERY or CREMATORY: Forest Lawn

24D. LOCATION (City, town, or county) (State): Dundalk, Balt Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Fabiano

25C. FUNERAL DIRECTOR: Wm. Bradley

ADDRESS: Dundalk, Md.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0396 Registered No. 67 0396

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Washington John P

2. DATE AND HOUR OF DEATH: 1-10-67 | 8:27 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Charles C.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Marbury 58-00
D. STREET ADDRESS (If rural, give location): Box 42

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widower
8. DATE OF BIRTH: 5/14/94
9. AGE (In years last birthday): 72 68
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter-Retired
10B. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Marbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Washington
14. MOTHER'S MAIDEN NAME: Susie Dorsey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-30-3119
17. INFORMANT: Richard B. Washington ADDRESS: Marbury, Md.

MEDICAL CERTIFICATION

1B. 177X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Carcinoma of the
DUE TO
(B) prostate
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or Not): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1-2 1967 to 1-10 1967, that (I) (~~we~~) last saw the deceased alive on 1-10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David S Fedson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-10-67

23C. PHYSICIAN'S NAME (Type): David S. Fedson M.D.
23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/1967
24C. NAME of CEMETERY or CREMATORY: Pleasant Grove Cemetery
24D. LOCATION (City, town, or county) (State): Marbury, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: Arehart Funeral Home, Inc., La Plata, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-623

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0397

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0397

1. NAME OF DECEASED (Type or Print): Gerst, Annie

2. DATE AND HOUR OF DEATH: January 10, 1967 | 9:35 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Balto Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): Perry Hall, Box 249 21128

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 3-22-1890

9. AGE (In years last birthday): 76 yrs.

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Michael Kinlein

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-26-7036

17. INFORMANT: Michael Gerst

ADDRESS: same

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarction — 12 hrs.

DUE TO

(B) Arteriosclerotic Heart Dis. — several years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 10 1967 to June 10 1967, that (I) (we) last saw the deceased alive on June 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-10-67

23C. PHYSICIAN'S NAME (Type): MENITA R. SUAREZ M.D.

23D. ADDRESS: Church Home + Hosp.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-14-1967

24C. NAME OF CEMETERY or CREMATORY: St. Joseph's Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Faber M.D.

25C. FUNERAL DIRECTOR: Loughran Funeral Home

ADDRESS: 3401 Belair Rd.

36

VS 150-REV. 1/1/65

H-534

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0398

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0398

1. NAME OF DECEASED (Type or Print): HANDEL, JOSEPH W.

2. DATE AND HOUR OF DEATH: JANUARY 12, 1967 | 1:30P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 21223 20-03

D. STREET ADDRESS (If rural, give location): 512 S. PAYSON ST.

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 7-19-94

9. AGE (In years last birthday): 72

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN M. Handel

14. MOTHER'S MAIDEN NAME: THERESA NORRIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NONE (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-14-9618

17. INFORMANT: ST. AGNES HOSPITAL RECORDS ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 155.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma,

DUE TO

(B) bile duct

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DECEMBER 19 19 66 to JANUARY 12 19 67, that (I) (we) last saw the deceased alive on JANUARY 12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Hilleroaard M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 1/12/67

23C. PHYSICIAN'S NAME (Type): ROLANDO DEL ROSARIO M.D.

23D. ADDRESS: ST. AGNES HOSP; CATON & WILKENS AVES.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-16-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Howard H. Hubbard, 4107 Wilkens Ave. 21229 ADDRESS:

VS 150-REV. 1/1/65

R-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0399

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0399

1. NAME OF DECEASED (Type or Print): CATHERINE S. RAAB

2. DATE AND HOUR OF DEATH: 1-13-67 | 2:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hosp. 100 N. Broadway Balto. 35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: 53-00

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 719 Old North Pt. Rd. (2)

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W

8. DATE OF BIRTH: 5-15-91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Seamstress

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: JOHN BECK

14. MOTHER'S MAIDEN NAME: CATHERINE PHIEFER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 219-22-5859A

17. INFORMANT: Margaret Sullivan (dgtr.)

ADDRESS: same

MEDICAL CERTIFICATION

1B. 420.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary thrombosis — DAYS

DUE TO Arteriosclerotic Heart Disease

(B) Cerebrovascular Accident - thrombosis - days

DUE TO

(C) Hypertension

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-12 1967 to 1-13 1967, that (I) (we) last saw the deceased alive on 1-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Norma Penaflor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-13-67

23C. PHYSICIAN'S NAME (Type): NORMA PENAFLOR M.D.

23D. ADDRESS: Church Home & Hospital Baltimore

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-16-1967

24C. NAME of CEMETERY or CREMATORY: St. Joseph's Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Kalbfus

25C. FUNERAL DIRECTOR: Leasch Funeral Home

ADDRESS: 3401 Belair Road (34)

VS 150-REV. 1/1/65

0-2-20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0400

Registered No. 67 00400

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROMAN OSIEWICZ

2. DATE AND HOUR OF DEATH: 1-11-67 2:17 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 35 CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2-02
D. STREET ADDRESS (If rural, give location): 103 S. BROADWAY (31)

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 5-31-90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FABRICATOR
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: STANLEY OSIEWICZ
14. MOTHER'S MAIDEN NAME: Marianna ? (OSIEWICZ)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 212 07 7329
17. INFORMANT: Mary Osiewicz
ADDRESS: Same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular disease ~~ASCVD~~ & congestive heart failure — years

DUE TO

(B) Pneumonia — days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-19 1966 to 1-11 1967, that (I) (we) last saw the deceased alive on 1-11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Francisco Baltazar M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): FRANCISCO BALTAZAR M.D.
23D. ADDRESS: CHURCH HOME & HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Holy Cross Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: R. Paul E. Fakuna
25C. FUNERAL DIRECTOR: Bruzdzinski Funeral Home
ADDRESS: 1407 Eastern Ave.

VS 150-REV. 1/1/65

48-26-22 IB

H-345 67 0401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0401

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Louis F. HEIDELMAIER

2. DATE AND HOUR OF DEATH: 1-13-67 | 12 50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): RURAL BALTIMORE COUNTY 53-00

D. STREET ADDRESS (If rural, give location): 8165 GRAYHAVEN ROAD #21222

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-28-97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Shipyard Worker, Bethlehem Steel Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN HEIDELMAIER

14. MOTHER'S MAIDEN NAME: MARY ELIZABETH YEAGER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705-10-2275

17. INFORMANT: RECORDS-BCH-4940 EASTERN AVENUE

ADDRESS: #21224

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.0 + 199.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic pulmonary disease, Adenocarcinoma.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-8 1966 to 1-13 1967, that (I) (we) last saw the deceased alive on 1-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Carlos R. Hamilton M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-13-67

23C. PHYSICIAN'S NAME (Type): DR. CARLOS R. HAMILTON M.D.

23D. ADDRESS: BCH-4940 EASTERN AVENUE #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/16/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Fabiano

25C. FUNERAL DIRECTOR: John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-34-70
NIW

BIRTH NO. 67 0402

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0402

1. NAME OF DECEASED (Type or Print): Karwacki, Michael P.

2. DATE AND HOUR OF DEATH: 1/12/67m | 7 6:40 p M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1-01
D. STREET ADDRESS (If rural, give location): 3127 ELLIOTT STREET - 21224

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
MALE	WHITE	WIDOWED	8/28/02	64		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
GUARD	United States Lines	MARYLAND	U.S.A.

13. FATHER'S NAME: JOHN KARWACKI

14. MOTHER'S MAIDEN NAME: Michalina Goscinski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-01-4637

17. INFORMANT: RECORDS: BCH, 4940 EASTERN AVE, Balto. Md. 21224 — ADDRESS

MEDICAL CERTIFICATION

1B. 181.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Carcinoma of the bladder

(A) DUE TO

(B) DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Dehydration

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		NO	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 11/3 19 66 to 1/12/ 19 67, that ~~(I)~~ (we) last saw the deceased alive on 1/12/ 19 67 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: Peter J Rosen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 1/12/67

23C. PHYSICIAN'S NAME (Type): Peter J. Rosen M.D.

23D. ADDRESS: BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTO, MD. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Jan-17-1967	St. Stanislaus	Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Fairbairn	John J. Duda	Baltimore, Maryland 21224

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-5321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0403
M.E. CASE NO.
Registered No. 67 0403

1. NAME OF DECEASED (Type or Print): Thomas L. Bands

2. DATE AND HOUR OF DEATH: Jan 14, 1967 | 7:20 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 33-00
D. STREET ADDRESS (If rural, give location): 8118 Old Harford Rd

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 7-16-85
9. AGE (In years last birthday): 81
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired, Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: U. S. Steel Co.
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: ? Henry Bands
14. MOTHER'S MAIDEN NAME: ? Avarina Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-03-7932
17. INFORMANT: John Bands (Son) ADDRESS: 2 Avery CT. Balto. #6

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 500X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute tracheobronchitis with left lower lobe atelectasis

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Double ureter on left. duodenal ulceration large.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 7 1967 to Jan. 14 1967, that (I) (we) last saw the deceased alive on Jan. 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/14/67
23C. PHYSICIAN'S NAME (Type): W. Michael Gould M.D.
23D. ADDRESS: Md. General Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan-18-1967
24C. NAME of CEMETERY or CREMATORY: Sacred Heart of Jesus
24D. LOCATION (City, town, or county) (State): German Hill Rd. Dundalk, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fahey, M.D.
25C. FUNERAL DIRECTOR: John J. Duda, ADDRESS: Dundalk, Maryland 21222

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-60-01

BIRTH NO. 67 0404

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0404

1. NAME OF DECEASED (Type or Print): Raymond Myers

2. DATE AND HOUR OF DEATH: 1/13/67 13:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY: Baltimore City

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2601

D. STREET ADDRESS (If rural, give location): 4429 Forest View Ave

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 8/7/00

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10B. KIND OF BUSINESS OR INDUSTRY: Food

11. BIRTHPLACE (State or foreign country): York, Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Myers

14. MOTHER'S MAIDEN NAME: Flora Hively

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-09-8257

17. INFORMANT: Hosp Chart

ADDRESS:

MEDICAL CERTIFICATION

18. 420.1 + 1260X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac Arrest — 0

DUE TO

(B) Coronary Insufficiency — 10 yrs

DUE TO

(C) Arteriosclerosis — 30 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus — 15 yrs

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/5/ 1967 to 1/13 1967, that (I) (we) last saw the deceased alive on 1/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nate E. Z. [illegible] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): Burial M.D.

23D. ADDRESS: Md. Gen. Hosp

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-16-1967

24C. NAME of CEMETERY or CREMATORY: Moreland Memorial Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Fellows

25C. FUNERAL DIRECTOR: Lazarath Funeral Home

ADDRESS: 36 7401 Belair Road

VS 150-REV. 1/1965

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-656

BIRTH NO. 67 0405

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0405

1. NAME OF DECEASED (Type or Print): WERNER, JOHN, A.

2. DATE AND HOUR OF DEATH: 1-12-67 5:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): NORTH CHARLES GENERAL HOSPITAL

49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: BALTO. CO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): ~~BALTO~~ # 21222, DUNDALK 53-00

D. STREET ADDRESS (If rural, give location): 51 WATERVIEW ROAD

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-7-1897

9. AGE (In years last birthday): 70

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: CROWN CORK & SEAL CO.

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN E. WERNER

14. MOTHER'S MAIDEN NAME: CATHERINE MULLER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: 213-01-0563

17. INFORMANT: HELEN E. WERNER

ADDRESS: SAME

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 792 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 5, 1967 19 to JAN. 12 19 67, that (I) (we) last saw the deceased alive on JAN 12 5:15 pm 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Chanthana Suddhimondaka M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-12-67

23C. PHYSICIAN'S NAME (Type): MARCOS LEVIN M.D.

23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-16-67

24C. NAME of CEMETERY or CREMATORY: OAK LAWN CEM.

24D. LOCATION (City, town, or county) (State): 7225 EASTERN BLVD. BALTO CO., MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Fackenthal

25C. FUNERAL DIRECTOR: Charles A. Geiler

ADDRESS: 6224 Eastern Ave. Baltimore, 21224, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

30/67 - See Letter in Doc file - Bur of Biostatistics
American Bldg - n

S-352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0406 Registered No. 67 0406

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOHN F. STENCER

2. DATE AND HOUR OF DEATH: January 12, 1967 | 5:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 House in the Pines 5837 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Essex (21) 53-00

D. STREET ADDRESS (If rural, give location): 1646 Eastern Ave. Apt. "G"

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	May 3, 1885	81		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Aircraft Mfg. Co.	Baltimore, Md.	USA

13. FATHER'S NAME: Michael Stencer

14. MOTHER'S MAIDEN NAME: Rosalie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216 03 3695

17. INFORMANT: Anna Stencer ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
1B. 420.1		
(A)	Coronary Occlusion	2 days
DUE TO (B)	ASCVD	2 yrs
DUE TO (C)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from July 1 1966 to 1/12 1967, that (I) (we) last saw the deceased alive on 1/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-14-67

23C. PHYSICIAN'S NAME (Type): [signature] M.D.

23D. ADDRESS: Balto 6 Md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/16/67

24C. NAME of CEMETERY or CREMATORY: St. Stanislaus Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Faber, M.D.

25C. FUNERAL DIRECTOR: [signature] ADDRESS: Bruzdzinski Funeral Home 1407 Eastern Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-100

BIRTH NO. 67 0407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0407

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anna Cohen

2. DATE AND HOUR OF DEATH: Jan 12, 1967 10 30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2701 Uhler Ave

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2717

D. STREET ADDRESS (If rural, give location): 2701 Uhler Ave

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH:

9. AGE (In years last birthday): 77

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathan Katz

14. MOTHER'S MAIDEN NAME: Fannie ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Miss Ida Cohen — ADDRESS: 2701 Uhler Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 & 1533		
(A)	Acute Coronary Thrombosis	sudden
DUE TO (B)	Arteriosclerotic Cardiovascular Dis	5 years
DUE TO (C)	Ventral Hernia	15 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	Ca of sigmoid colon resected	15 years ago

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from November 1959 to January 12 1967, that (I) (we) last saw the deceased alive on January 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Cecil Rudner M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-12-67

23C. PHYSICIAN'S NAME (Type): CECIL RUDNER MD M.D.

23D. ADDRESS: 6821 Reisterstown Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 13/67

24C. NAME of CEMETERY or CREMATORY: Beth Hamedresh Hagodol

24D. LOCATION (City, town, or county) (State): Rosedale, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Sol Levinson & Bros Inc

ADDRESS: 6010 Reist Road

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0408 Registered No. 67 0408

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELLIS JACOBS

2. DATE AND HOUR OF DEATH: JANUARY 10 1967 11 55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 15-12

D. STREET ADDRESS (If rural, give location): 2912 HILLDALE AVE

5. SEX: Male

6. RACE: CAUC

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: ?

9. AGE (In years last birthday): 86

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Policeman

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Jacobs

14. MOTHER'S MAIDEN NAME: ? Wertheimer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. JoAnne Solomon, 14 Martin Court, ADDRESS: Great Neck, Long Island, N. Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIAC ARREST

DUE TO

(B) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JAN 7 1967 to JAN 10 1967, that (I) (we) last saw the deceased alive on JAN 10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Melvyn B Lewis M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: JAN 10, 1967

23C. PHYSICIAN'S NAME (Type): Melvyn B. Lewis M.D.

23D. ADDRESS: SINAI HOSPITAL OF BALTO.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/13/67

24C. NAME of CEMETERY or CREMATORY: Chizuk Amuno (Arlington)

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-100

BIRTH NO. 67 0409

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0409

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Samuel Levy

2. DATE AND HOUR OF DEATH: January 10, 1967 | 10:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Belvedere Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-01

D. STREET ADDRESS (If rural, give location): Temple Garden Apartments, Apt. 1103 #17

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH

9. AGE (In years last birthday): 86

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manufacture

10B. KIND OF BUSINESS OR INDUSTRY: Men Shirts

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-32-9034

17. INFORMANT: Mrs. Ellis Hyman

ADDRESS: 5601 Everhurst Road #9

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) arteriosclerotic Heart Disease — 5 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/15 1960 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: I Zinberg MD — M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): Dr. Israel Zinberg M.D.

23D. ADDRESS: 4000 W. Northern Parkway #15

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/11/67

24C. NAME of CEMETERY or CREMATORY: Chizuk Amuno (Arlington)

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Barker, M.D.

25C. FUNERAL DIRECTOR: Sol Levinson & Bros. Inc.

ADDRESS: 6010 Reist., Rd.

VS 150-REV. 1/1/65

1
W-200

BIRTH NO. 67 0410

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0410

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THOMAS WISE

2. DATE AND HOUR PRONOUNCED DEAD: January 11, 1967 | 2:55 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 1905 Homewood Avenue

5. SEX: Male
6. RACE: Colored
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Seperated
8. DATE OF BIRTH: October 17, 1909
9. AGE (In years last birthday): 57
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hampton Sydney, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Wise
14. MOTHER'S MAIDEN NAME: Ella Stockes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-14-8383
17. INFORMANT: Margaret Neal, ADDRESS: 1905 Homewood Ave.

MEDICAL CERTIFICATION

18. E812.4

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Pulmonary Emboli
DUE TO
(B) Fracture of Right Leg
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Express Way
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2 mile marker Jones Falls Express Way 272 ft. S. of 13-04
21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 13 (Year) '66 (Hour) 12:22 P.M.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian hit by car.

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/11/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-15-67
23C. NAME of CEMETERY or CREMATORY: Mercy Seat Baptist Church
23D. LOCATION (City, town, or county) (State): Hampton Sydney, Va.

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: Robert E. Farber, M.D.
24C. FUNERAL DIRECTOR: Charles R. Law
ADDRESS: 802 Madison Ave.

VS 151-REV. 1/1/65

N 827.2

32-42-00 M-635
DH

BIRTH NO. 67 0411

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0411

1. NAME OF DECEASED (Type or Print): THELMA MORTON — Thelma Morton

2. DATE AND HOUR OF DEATH: Jan. 13, 1967 | 3:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND #21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 14-02
D. STREET ADDRESS (If rural, give location): 1408½ MADISON AVENUE #21215

5. SEX: FEMALE
6. RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 8-30-21
9. AGE (In years last birthday): 45
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): INDIANA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~GHATHER~~ Otha Turner
14. MOTHER'S MAIDEN NAME: MARY TUCKER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 212-28-2885
17. INFORMANT: BCH 4940 Eastern Avenue, Baltimore, Maryland #21224 — ADDRESS
RECORDS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 465 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: few hours

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Systemic Lupus Erythematosus

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Oct. 28 19 66 to Jan. 13 19 67, that (I) (we) last saw the deceased alive on 1/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Franklin G. Strauss M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/13/67
23C. PHYSICIAN'S NAME (Type): Franklin G. Strauss M.D.
23D. ADDRESS: Balt City Hosp 4940 Eastern Avenue, Baltimore, Md. #21224

24A. BURIAL CREMATION, REMOVAL (Specify): Removal
24B. DATE: 1/16/67
24C. NAME of CEMETERY or CREMATORY: Crown Hill
24D. LOCATION (City, town, or county) (State): Indianapolis Indiana

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Louis E. Fabiano
25C. FUNERAL DIRECTOR: Washington Phillips — ADDRESS: 1220 N. Monroe St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0412 Registered No. 67 0412

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William C. Hudnall

2. DATE AND HOUR OF DEATH: 1-13-67 | 10:30 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 524 Lanvale St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township): 14-03 D. STREET ADDRESS (If rural, give location): 524 Lanvale St

5. SEX: Male 6. RACE: Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Yes 8. DATE OF BIRTH: 4-1896 9. AGE (In years last birthday): 70 If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Northumberland Co Va 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hudnall 14. MOTHER'S MAIDEN NAME: Mary Hudnall

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service: 16. SOCIAL SECURITY NO. 320-9-9594 17. INFORMANT: Hortense Jackson ADDRESS: 524 Lanvale St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO

(B) Arterio Sclerotic Heart Disease — 3 yr

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0 — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): — 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-18-64 19 to 1-13 1967, that (I) (we) last saw the deceased alive on 1-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐ 23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type): G. Franklin Phillips M.D. 23D. ADDRESS: 558 McCulloh St Balto Md

24A. BURIAL CREMATION REMOVAL (Specify): Burial 24B. DATE: Jan 17/66 24C. NAME of CEMETERY or CREMATORY: Arbutus M. Park 24D. LOCATION (City, town, or county) (State): Baltimore

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967 25B. NAME OF REGISTRAR: [signature] 25C. FUNERAL DIRECTOR: W. Brooke Ringgold ADDRESS: 1463 N. Carey St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-1630

BIRTH NO. 67 0413

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0413

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARVIN BYRD

2. DATE AND HOUR PRONOUNCED DEAD: January 14, 1967 12:55 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 610 Ridgewood Avenue Richwood

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never Married
8. DATE OF BIRTH: Jan. 25, 1948
9. AGE (In years last birthday): 18
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Byrd
14. MOTHER'S MAIDEN NAME: Lena ~~XXXXXX~~ Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 248-82-6693
17. INFORMANT: Jordan Funeral home ADDRESS: Darlington, S.C.

MEDICAL CERTIFICATION

18. E9527

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of Chest.

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North Ave. & Kennedy Street

21D. TIME OF INJURY (APPROX.): (Month) 1 (Day) 14 (Year) '67 (Hour) A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Stabbed during altercation.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [X] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/17/67
23C. NAME of CEMETERY or CREMATORY: St John Cem.
23D. LOCATION (City, town, or county) (State): Darlington, S.C.

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: R. E. Fagan
24C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

N8752

0412

M-250

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0414 Registered No. 67 0414

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): PEARL MASON

2. DATE AND HOUR PRONOUNCED DEAD: January 13, 1967 8:20 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 39 Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1115 N. Parrish Street

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed
8. DATE OF BIRTH: 3-29-08
9. AGE (In years last birthday): 58
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217209387
17. INFORMANT: Fred Nelson
ADDRESS: 1629 Booker Court

MEDICAL CERTIFICATION

1B. E9010

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism
DUE TO
(B) Deep Vein Thrombosis
DUE TO
(C) Fracture of Left Tibia.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1115 N. Parrish Street 16-02
21D. TIME OF INJURY (APPROX.) (Month) 12 (Day) 23 (Year) '66 (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell off ladder.

22. I certify that I held on Inquiry [ ] Inspection [X] Autopsy [ ] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]
DATE SIGNED: 1/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-17-67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cem.
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: Robert E. Fairbanks
24C. FUNERAL DIRECTOR: George G. Kelson
ADDRESS: 1348 N. Calhoun St.

VS 151-REV. 1/1/65

N 823

P.654

BIRTH NO. 67 0415

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0415

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ROLAND PURNELL

2. DATE AND HOUR PRONOUNCED DEAD: January 12, 1967 6:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 677 W. Franklin Street

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 677 W. Franklin Street

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: May 10, 1915
9. AGE (In years last birthday): 51
If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Prunell
14. MOTHER'S MAIDEN NAME: Lara Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Pauline Stokes, 677 W. Franklin St. ADDRESS

MEDICAL CERTIFICATION

18. 331X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: January 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-17-67
23C. NAME of CEMETERY or CREMATORY: Mt. Auburn
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: Robert E. Fahrney
24C. FUNERAL DIRECTOR: Charles R. Law, 802 Madison Ave. ADDRESS

VS 151-REV. 1/1/65

G-25b

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0416 Registered No. 67 0416

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Herbert Gaskins

2. DATE AND HOUR OF DEATH: 1-13-67 9¼ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore
42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 5318 Denmore Ave.

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 10/5/14
9. AGE (In years last birthday): 52
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Horseman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Gaskins
14. MOTHER'S MAIDEN NAME: Mary Evens

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-16-6850
17. INFORMANT: Bertha Gaskins, 5318 Denmore Ave.
ADDRESS:

MEDICAL CERTIFICATION

1B. 420.1 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Myocardial Infarction — 1 day

(B) DUE TO: Arteriosclerotic Heart Disease

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~we~~ (this hospital) attended the deceased from 1-13 1967 to 1-13 1967, that ~~I~~ (we) last saw the deceased alive on 1-13 1967 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Allan S. Rudolph M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-13-67
23C. PHYSICIAN'S NAME (Type): Allan S. Rudolph M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-67
24C. NAME of CEMETERY or CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: Charles R. Law
ADDRESS: 802 Madison Ave.

VS 150-REV. 1/1/65

5-536

BIRTH NO. 67 0417

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0417

1. NAME OF DECEASED (Type or Print): PHYLLIS M. SANDERS
PHYLIS SANDERS

2. DATE AND HOUR PRONOUNCED DEAD: January 12, 1967 | 4:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3313 Mueller Street # 21284

26-11

31/99

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months / Days / Hours / Min.
Female	White	Widowed	Apr. 15, 1915	51	

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	At Home.	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: Anthony Stahl

14. MOTHER'S MAIDEN NAME: Catherine Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	-----	212-01-6185	James D. Stahl	Same.

MEDICAL CERTIFICATION

18. 416X

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED January 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-16-67.	Gardens of Faith	Kenwood Ave. and Trumps Mill Rd. Balto., Co., Md.

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Farley M.D.	Charles S. Geiler	901 S. CONKLING ST. BALTO., 21224, MD

VS 151-REV. 1/1/65

R-2001

BIRTH NO. 67 0418

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0418

1. NAME OF DECEASED (Type or Print) CLYDE ROSS.

2. DATE AND HOUR OF DEATH 1-13-67 10⁰⁵ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
LINCOLN memorial nursing Home.
27 N. CAREY STREET.
BALTIMORE, MARYLAND. 21223

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE.
D. STREET ADDRESS (If rural, give location) 1834 N. BRUNT STREET.

14-03

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
MALE	Negro	Widowed	10/17/1880	86				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Retired	upperville va	

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-24-0031

17. INFORMANT Lincoln Memorial Hospital 27 N. Carey Street ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 1538

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CANCER OF COLON

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-3 1965 to 1-13 1966, that (I) (we) last saw the deceased alive on 1-13 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED 1/13/66

23C. PHYSICIAN'S NAME (Type) HARRIS SENNARINE M.D.

23D. ADDRESS 930 Whitelock St

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1, 1967	White Baptist	upperville va

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	[signature]	[signature]	

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-49-32
NIW

10-500

BIRTH NO. 67 0419

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0419

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Cuno, Frederick R.

2. DATE AND HOUR OF DEATH: 1-13-67 2:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS, 4940 EASTERN AVENUE, BALTIMORE MARYLAND 21224
31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
26-10
D. STREET ADDRESS (If rural, give location): 3302 LEVERTON AVENUE - 21224

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 6/5/90
9. AGE (In years last birthday): 76
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance man
10B. KIND OF BUSINESS OR INDUSTRY: Balto. City
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FREDERICK CUNO
14. MOTHER'S MAIDEN NAME: RUTH Kirby

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW1
16. SOCIAL SECURITY NO.: 214-24-2405A
17. INFORMANT: RECORDS: BCH 4940 Eastern Ave., Balto. Md. 21224
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 153.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident — 1 day
DUE TO
(B) Metastatic bowel carcinoma — 5 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-13 19 67 to 1-13 19 67, that (I) (we) last saw the deceased alive on 1-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ross T. Krueger M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-13-67
23C. PHYSICIAN'S NAME (Type): Ross T. Krueger M.D.
23D. ADDRESS: 4940 EASTERN AVE, BALTO. MD. 21224 Balt. City Hospitals

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/67
24C. NAME of CEMETERY or CREMATORY: Sacred Heart of Jesus Cem.
24D. LOCATION (City, town, or county): Baltimore (State): Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: John A. Moran, Inc.
ADDRESS: 3000 E. Balto. St.

VS 150-REV. 1/1/65

10 K-626

BIRTH NO. 67 0420

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0420

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Louis F. Kruger

2. DATE AND HOUR OF DEATH: Jan. 13, 1967 | 5 45 a.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1 N. Wickham Rd. Baltimore, 29, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md.

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1 N. Wickham Rd.

28-04

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	Wh	Married	8-26-98	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired		Maryland	USA

13. FATHER'S NAME: John Kruger

14. MOTHER'S MAIDEN NAME: Barbara ---

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-09-7863

17. INFORMANT: Mrs. Louis F. Kruger — ADDRESS: 1 N. Wickham Rd.

MEDICAL CERTIFICATION

1B. 4201 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) DUE TO: Coronary Thrombosis — 5 hs.

(B) DUE TO:

(C) ~~Arteriosclerotic Heart Disease~~

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Arteriosclerotic Heart Disease

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from January 13 1967 to January 13 1967, that (I) (we) last saw the deceased alive on January 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: A. Galindo M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type or Print): Antonio Galindo M.D.

23D. ADDRESS: 303 N. Rolling Road

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-16-67	Lorraine Park Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Jackson	Wiczke F.D.	4101 Edmondson Ave.

VS 150-REV. 1/1/65

1 4
C-535

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 67 0421 Registered No. 67 0421

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FRANCIS CAMTION

2. DATE AND HOUR PRONOUNCED DEAD: January 13, 1967 4:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 416 Fonthill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 30-06
D. STREET ADDRESS (If rural, give location): 416 fonthill Avenue

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 4-15-99
9. AGE (In years last birthday): 67 ~~65~~
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Monarch Aluminum
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Late - John
14. MOTHER'S MAIDEN NAME: Late - Sophie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 284-03-7195A
17. INFORMANT: Mrs. Elizabeth Campion
ADDRESS: 4407 Walker Ave.

MEDICAL CERTIFICATION

18. 581.0

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fatty Liver.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arteriosclerotic Cardiovascular Disease.

19A. DATE OF OPERATION: 22
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: 1/14/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-17-67
23C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.
23D. LOCATION (City, town, or county) (State): Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: Robert E. Falkenstein
24C. FUNERAL DIRECTOR: Witzke F.D.-4101 Edmondson Ave.
ADDRESS:

0 4 2 0

VS 151-REV. 1/1/65

4-320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0422 Registered No. 67 0422

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CHARLES JOSEPH HUDAK, SR.

2. DATE AND HOUR OF DEATH: 1-11-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2435 JEFFERSON ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2435 JEFFERSON ST.

6-02

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 1-23-1895
9. AGE (In years last birthday): 71
If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DETECTIVE
10B. KIND OF BUSINESS OR INDUSTRY: POLICE DEPT.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL HUDAK
14. MOTHER'S MAIDEN NAME: ANNA VELENOSKY

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Pauline M. Hudak
ADDRESS: 2435 Jefferson St.

MEDICAL CERTIFICATION

18. 153.8

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) CANCER - COLON — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 1966
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: DIAGNOSTIC
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from DEC. 19 66 to 1-11- 19 67, that (I) (~~we~~) last saw the deceased alive on 1-10- 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and ~~from~~ the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Benj. B. Moses, M.D.
Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-13-67
23C. PHYSICIAN'S NAME (Type): BENJ. B. MOSES M.D.
23D. ADDRESS: 448 N. LUZERNE AVE

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: HOLY REDEEMER CEM.
24D. LOCATION (City, town, or county) (State): BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT. JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fulcome
25C. FUNERAL DIRECTOR: Hartley Miller
ADDRESS: 2334 Jefferson St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

67 0423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0423

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Ferrucci, Nicholas

2. DATE AND HOUR OF DEATH: 1-19-67 12:50 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE

D. STREET ADDRESS (If rural, give location): 602 N. PORT ST.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	8-21-96	70		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoemaker

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Foggia, Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Matthew

14. MOTHER'S MAIDEN NAME: Constance Fratta

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-18-9408A

17. INFORMANT: Mrs. Ferrucci

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 4201

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Gouty renal disease

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/2 1967 to 1/13 1967, that (I) (we) last saw the deceased alive on 1/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Murray A. Katz M.D.

Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): MURRAY A. KATZ M.D.

23D. ADDRESS: JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/67

24C. NAME of CEMETERY or CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Joseph [illegible]

ADDRESS: 263 S. Conkling

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FERRUCCI, NICHOLAS

#94 68 27

V-45

BIRTH NO. 67 0424

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0424

1. NAME OF DECEASED (Type or Print): THEODORE P. VALMAS.

2. DATE AND HOUR OF DEATH: 1-13-67 | 2:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD. B. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 1-03

D. STREET ADDRESS (If rural, give location): 2425 EASTERN AVE

5. SEX: M

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 4-01-97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tugboat fireman

10B. KIND OF BUSINESS OR INDUSTRY: (Retired)

11. BIRTHPLACE (State or foreign country): GREECE

12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-14-1875

17. INFORMANT: Chart

ADDRESS

MEDICAL CERTIFICATION

1B. 132X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Abdominal Carcinomatosis

DUE TO primary pancreatic tail

(B)

DUE TO

(C) Intestinal obstruction Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/9 1967 to 1/13 1967, that (I) (we) last saw the deceased alive on 1/13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: George N. Agapitos, M.D.

Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): Agapitos George M.D.

23D. ADDRESS: M.G.H.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/16/67

24C. NAME of CEMETERY or CREMATORY: Oaklawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Joseph A. Zimmerman

ADDRESS: 263 S. Conkling St

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0425

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0425

1. NAME OF DECEASED (Type or Print): Reed, Helen Rebecca

2. DATE AND HOUR OF DEATH: 1-10-67 | 11:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1524 McCulloh Street

14-02

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 10/16/92

9. AGE (In years last birthday): 70

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George Wood

14. MOTHER'S MAIDEN NAME: Emma Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Richard Reed

ADDRESS:

MEDICAL CERTIFICATION

18. 495X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pneumonia

DUE TO probably pneumococcal

(B)

DUE TO

(C) Cardiac arrest

INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CVA

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?:

22. I certify that (I) (~~this hospital~~) attended the deceased from 1-10 1967 to 1-10 1967, that (I) (~~we~~) last saw the deceased alive on 1-10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: David S Fedson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-10-67

23C. PHYSICIAN'S NAME (Type): David S. Fedson M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Jan 14/67

24B. DATE: Jan 14/67

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem

24D. LOCATION (City, town, or county) (State): Wilkinson Balto, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Louis F. Dickerson

ADDRESS: 1129 N. Carlton St

VS 150-REV. 11/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 0426 66-23711

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0426

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): YVONNE DAVIDSON (Baby)

2. DATE AND HOUR PRONOUNCED DEAD: January 7, 1967 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05

D. STREET ADDRESS (If rural, give location): 1618 Normal Avenue

5. SEX: Female

6. RACE: Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): —

8. DATE OF BIRTH: Nov. 5, 1966

9. AGE (In years last birthday):

If Under 1 Yr. Months: 2 Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Larry E. Davidson

14. MOTHER'S MAIDEN NAME: Darbie Somerville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Darbie Somerville ADDRESS: 1618 Normal

MEDICAL CERTIFICATION

1B. 525X I

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial Pneumonitis (SDII)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/8/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-13-67

23C. NAME of CEMETERY or CREMATORY: Mt. Calvary Cem.

23D. LOCATION (City, town, or county) (State): B.A. County, Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

24B. NAME OF REGISTRAR: Robert E. Fortuna

24C. FUNERAL DIRECTOR: Milton E. Elchon

ADDRESS: 129 N. Carol

VS 151-REV. 1/1/65

R-306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0427 Registered No. 67 0427

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): William Reid

2. DATE AND HOUR OF DEATH: 1/10/67 1:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore D. STREET ADDRESS (If rural, give location): 1311 North Ellwood Avenue

5. SEX: Male 6. RACE: Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married 8. DATE OF BIRTH: 5/19/04 9. AGE (In years last birthday): 62 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 10B. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): Balto. Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Reid 14. MOTHER'S MAIDEN NAME: Gertrude Boyd

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT: Martha Reid ADDRESS: 1311 N. Ellwood Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asystole — —

DUE TO

(B) Hypotension & Resp arrest — 12 hrs

DUE TO

(C) CVA — 3 days

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension — 3 yrs

19A. DATE OF OPERATION: — 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): — 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1/7 1967 to 1/10 1967, that (I) (~~we~~) last saw the deceased alive on 1/10 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: S. Mishkin M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 1/10/67

23C. PHYSICIAN'S NAME (Type): S. MISHKIN M.D. 23D. ADDRESS: JHH

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: Jan 14/67 24C. NAME of CEMETERY or CREMATORY: Arbutus Mem Park 24D. LOCATION (City, town, or county): Arbutus (State): Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967 25B. NAME OF REGISTRAR: R. Bruce Farley M.D. 25C. FUNERAL DIRECTOR: Frank E. Erickson ADDRESS: 1129 N. Carlton St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0428 Registered No. 6667 0428

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): GORDON DRAKE

2. DATE AND HOUR OF DEATH: 1/10/67 1:10 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 100 N. Broadway Baltimore CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 3-01
D. STREET ADDRESS (If rural, give location): 30 N. CAROLINE ST.

5. SEX: M
6. RACE: COLORED
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): UNKNOWN
8. DATE OF BIRTH: UNKNOWN
9. AGE (In years last birthday): 72
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): UNKNOWN
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Willis King (Friend) ADDRESS: 30 N. Caroline St.

MEDICAL CERTIFICATION

1B. 1099 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) ACUTE RENAL FAILURE — DAYS
DUE TO
(B) SEVERE DEHYDRATION AND INFECTION — DAYS
DUE TO
(C) Gastro Intestinal Bleeding — days
due to Malignancy with possible metastasis — years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: [signature] CHIEF OR ASST. MEDICAL EXAMINER. N.A. 1/16/67

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/6 1967 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Norma Penafior M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-10-66
23C. PHYSICIAN'S NAME (Type): NORMA PENAFIOR M.D.
23D. ADDRESS: Church Home & Hospital 100 N. Broadway Balto.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-14-67
24C. NAME of CEMETERY or CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Parker
25C. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brooklyn Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released by the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RELEASED BY MEDICAL EXAMINER ON APPROVAL

D-200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0429
M.E. CASE NO. 67 0429
Registered No. 67 0429

1. NAME OF DECEASED (Type or Print): Dix, Nathaniel

2. DATE AND HOUR OF DEATH: 1-12-67 7:15P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 39 Provident Hospital, Inc. Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 16-01
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 923 N Carrollton Ave.

5. SEX: Male
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 1951
9. AGE (In years last birthday): 15
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Cummings
14. MOTHER'S MAIDEN NAME: Bertha Day

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Amanda Lee Same
ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 204.9 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Leukemia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-12-67 19 to 1-12-67 19, that (I) (we) last saw the deceased alive on 1-12-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-13-67
23C. PHYSICIAN'S NAME (Type): C. Loredo M.D.
23D. ADDRESS: 1514 Division Street

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: [signature]
25C. FUNERAL DIRECTOR: Leroy A. Wilson
ADDRESS: 1000 Brantly Ave

VS 150-REV. 1/1/65

R. 152

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67 0430

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0430

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FLORENCE ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD: January 12, 1967 11:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 902 W. Franklin Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write SUBAC and give township): Baltimore 18-01

D. STREET ADDRESS (If rural, give location): 902 W. Franklin Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Married	Nov 25-1891	74		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md	U S A

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-12-4975

17. INFORMANT: Charles Robinson ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		No	

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 12, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1-16-67	Mt Auburn Cem	Balto Md

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Farley M.D.	Elroy O. Wilson	1010 Bennett Pl

VS 151-REV. 1/1/65

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M 252

BIRTH NO. 67 0431

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0431

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JAMES John McNISH

2. DATE AND HOUR PRONOUNCED DEAD: January 15, 1967 | 4:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1534 N. Carey Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 15-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1534 N. Carey Street

5. SEX: Male

6. RACE: Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify):

8. DATE OF BIRTH: 1887

9. AGE (In years last birthday): 79

If Under 1 Yr. If Under 24 Hrs. Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Jamacia BWI

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mable Cumbagh ADDRESS: 25 S. Morely St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic CardiovascularDisease. 4221

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/15/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/18/67

23C. NAME of CEMETERY or CREMATORY: Mt/ Auburn

23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

24B. NAME OF REGISTRAR: Robert E. Lackey M.D.

24C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 151-REV. 1/1/65

Dr. Sopher 1

e. 632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0432 Registered No. 67 0432

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): BESSIE CURTIS

2. DATE AND HOUR OF DEATH: JAN 10, 1967 5 00 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: 18-03
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 1025 BOOTH ST.

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): SINGLE
8. DATE OF BIRTH: 3/11/15
9. AGE (In years last birthday): 51
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ROBERT THORNE
14. MOTHER'S MAIDEN NAME: LENA CURTIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS
ADDRESS

MEDICAL CERTIFICATION

18. I 15-0X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) PNEUMONIA — 36 hrs.
DUE TO
(B) CARCINOMA of Esophagus — 4 Months
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Esophagectomy, Gastrostomy

19A. DATE OF OPERATION: 1/4/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Ca Esophagus
20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/9 1966 to 1/10 1967, that (I) (we) last saw the deceased alive on 1/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Irvin M. Sopher M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/10/67
23C. PHYSICIAN'S NAME (Type): IRVIN M. SOPHER M.D.
23D. ADDRESS: University Hospital, Balto. Md.

24A. BURIAL CREMATION REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Faulkner
25C. FUNERAL DIRECTOR: Charles A. Rice 661 W Baltimore
ADDRESS

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6261

BIRTH NO. 67 0433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0433

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Coleman Berger

2. DATE AND HOUR OF DEATH: January 15, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2409 S. Paca Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 25-33

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2409 S. Paca Street

5. SEX: M.

6. RACE: C.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 4/25/1900

9. AGE (In years last birthday): 66

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Berger

14. MOTHER'S MAIDEN NAME: Tinie Gray

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW1

16. SOCIAL SECURITY NO.: 213-10-5352A

17. INFORMANT: Mamie Berger ADDRESS: 2409 S. Paca Street.

MEDICAL CERTIFICATION

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebrovascular accident (Thrombosis)

DUE TO

(B) Hypertensive Cardio-Vascular Dis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH: up to hours

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/22/1959 to 1/15/1967, that (I) (we) last saw the deceased alive on 1/5/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John S. Braxton M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/16/67

23C. PHYSICIAN'S NAME (Type): JOHN S. BRAXTON JR M.D.

23D. ADDRESS: 922 S. SHARP, BALT. 30, MD.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/19/67

24C. NAME of CEMETERY or CREMATORY: Baltimore National

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0434 Registered No. 67 0434

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Anderson, Rosetta

2. DATE AND HOUR OF DEATH: 1/10/67 4:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dukeland nursing Home 90 1501 Dukeland st.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1702
D. STREET ADDRESS (If rural, give location): 1213 Etting St.

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 11/29/01
9. AGE (In years last birthday): 65
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domewtic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Cora Madison

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dukeland nursing Home
ADDRESS: 1501 Dukeland St.

MEDICAL CERTIFICATION

18. #2011 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CORONARY THROMBOSIS — 1 day
DUE TO
(B)
DUE TO
(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-10 1966 to 1-10 1967, that (I) (we) last saw the deceased alive on 1-10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Thomas W. Harris M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-10-67
23C. PHYSICIAN'S NAME (Type) M.D.:
23D. ADDRESS:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/15/67
24C. NAME of CEMETERY or CREMATORY: Mt Auburn Cemetry
24D. LOCATION (City, town, or county) (State): Baltimore Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fakuma
25C. FUNERAL DIRECTOR: Adolphus Halstead
ADDRESS: 1206 W North Ave

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-67

BIRTH NO. 67 0435

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0435

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): OWEN ROBERT FORREST

2. DATE AND HOUR OF DEATH: 1/14/67 1:12 p.m.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 100 N. Baltimore. CHURCH HOME AND HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1742 E. LOMBARD ST

35 2-02

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	MARRIED	1-28-09	57		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TECHNICIAN	ELECTRIC	NEW ZEALAND	U.S.A

13. FATHER'S NAME: OWEN G. FORREST

14. MOTHER'S MAIDEN NAME: ETHEL UNK

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	WORLD WAR II	214-26-8263	ELIZABETH FORREST	1742 E LOMBARD ST

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
1B. 260X		
(A) DUE TO	UREMIA	DAYS
	Congestive Heart Failure Compensated	
(B) DUE TO	ARTERIOSCLEROTIC HRT. DISEASE	YEARS
(C)	DIABETES MELLITUS	YEARS

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0		✓	

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/1 1967 to 1/14 1967, that (I) (we) last saw the deceased alive on 1/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Norma Penaflor M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-14-67

23C. PHYSICIAN'S NAME (Type): NORMA PENAFLOR M.D.

23D. ADDRESS: Church Home + Hosp. Baltimore

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: JAN 17 1967

24C. NAME of CEMETERY or CREMATORY: HOLY REDEEMER CEM

24D. LOCATION (City, town, or county) (State): 4430 BELAIR RD MD

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: DIPPEL BROS INC ADDRESS: 1800 E LOMBARD ST

VS 150-REV. 1/1/65

H-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0436 Registered No. 67 0436

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): John S. Huntchen

2. DATE AND HOUR OF DEATH: 1/12/67 12:00 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Funeral Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto. City
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 3536 Greenmount Ave

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: 12/3/1879
9. AGE (In years, last birthday): 87
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Unk~~ Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Racing Commission
11. BIRTHPLACE (State or foreign country): Balto, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk
14. MOTHER'S MAIDEN NAME: Unk

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 203-09-1329
17. INFORMANT: Hosp. Chart
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. 572.2

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular Shock — INTERVAL BETWEEN ONSET AND DEATH: 5 Hrs
DUE TO
(B) Dehydration — 48 Hrs
DUE TO
(C) Ulcerative Colitis — 6 Mos

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: ☐ While At Work ☐ Not While At Work
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 1/7/1967 to 1/12/1967, that ~~(I)~~ (we) last saw the deceased alive on 1/12/1967 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE: D. Zickafoss M.D. ☐ Attending Phys. ☐ Med. Director ☐ Staff Phys.
23B. DATE SIGNED: 1/12/67
23C. PHYSICIAN'S NAME (Type): D. Zickafoss M.D.
23D. ADDRESS: Md. Gen. Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-67
24C. NAME of CEMETERY or CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fashum
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-232

BIRTH NO. 67 0437

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0437

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Stanley E. Rustic

2. DATE AND HOUR OF DEATH: January 12, 1967 | 11:00A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1305 Windemere Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-03
D. STREET ADDRESS (If rural, give location): 1305 Windemere Ave.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	W	Married	8/15/1898	68		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Clerk	Court	Baltimore, Md.	U.S.A.

13. FATHER'S NAME: William Patrick Rustic

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Coleman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-01-5436

17. INFORMANT: Mrs. Anne Regina Rustic — ADDRESS: (Same)

MEDICAL CERTIFICATION

CAUSE OF DEATH

I — 1B. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO: Arteriosclerotic C-V disease — 8 yrs.

(B) DUE TO:

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonary emphysema

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from Jan. 10 1957 to Jan. 12 1967, that (I) (~~we~~) last saw the deceased alive on Jan. 11 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Wm. H. Grenzer M.D. — Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1.13.67

23C. PHYSICIAN'S NAME (Type): William H. Grenzer M.D.

23D. ADDRESS: 1520 E. 33rd St.

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/16/67	Druid Ridge	Pikesville, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR: 1967 0 0 0437

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. — ADDRESS: 4905 York Rd. Balto.12, Md.

VS 150-REV. 1/1/65

B-600

BIRTH NO. 67 0438

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0438

1. NAME OF DECEASED (Type or Print): (Mr.) BAER, BANKARD FREDERICK

2. DATE AND HOUR OF DEATH: 14 JAN 1967, 2:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-12

D. STREET ADDRESS (If rural, give location): 330 ST. DUNSTAN'S RD.

44

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 05-30-1895

9. AGE (In years Last birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED - EDUCATOR

10B. KIND OF BUSINESS OR INDUSTRY: DEPT. OF EDUCATION BALTO. CITY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? (USA) AMERICAN

13. FATHER'S NAME: JOHN BAER

14. MOTHER'S MAIDEN NAME: AURORA STEUCRER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 213-36-8737

17. INFORMANT: MRS. HAZEL V. BAER ADDRESS: (SAME)

MEDICAL CERTIFICATION

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute myocardial infarction

DUE TO

(B) Coronary arteriosclerosis

DUE TO

(C)

A. Vigolito, Jr. M.D.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 13 JAN 1967 to 14 JAN 1967, that (I) (we) last saw the deceased alive on 14 JAN 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjof Bjornsson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. X

23B. DATE SIGNED: 14 JAN '67

23C. PHYSICIAN'S NAME (Type or Print): DR FRIDTJOF BJORNSSON M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/18/1967

24C. NAME of CEMETERY or CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Balto.Co., Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto.12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0439 Registered No. 67 0439

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Charles Milton Vincent

2. DATE AND HOUR OF DEATH: Jan.13,1967 8:45PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N.Charles General Hospital

49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 12 22-38
D. STREET ADDRESS (If rural, give location): 1413 Gittings Ave.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 7-21-1892
9. AGE (In years last birthday): 74
If Under 1 Yr. Months Days: If Under 24 Hrs. Hours Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales
10B. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harry Joseph Vincent
14. MOTHER'S MAIDEN NAME: Mollie Law
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW1
16. SOCIAL SECURITY NO. 212-10-8026
17. INFORMANT: Edna M. Vincent ADDRESS: Above

MEDICAL CERTIFICATION

1B. 4221 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Apoplexy — multiple attacks last of 1 months duration.
DUE TO
(B) Arteriosclerotic Cardiovascular Disease — at least 15 yrs. duration
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1956 19 to Jan. 19 67, that (I) (~~we~~) last saw the deceased alive on Jan. 13 19 67 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (~~did not~~) view the body after death.

23A. SIGNATURE: Robert Gebhardt M.D. M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/16/1967
23C. PHYSICIAN'S NAME (Type): Robert Gebhardt M.D.
23D. ADDRESS: 1211 Northern Parkway, Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-16-67
24C. NAME of CEMETERY or CREMATORY: Dulaney Valley
24D. LOCATION (City, town, or county) (State): Timonium Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fabian M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0440 Registered No. 67 0440

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Robert Morton Williams

2. DATE AND HOUR OF DEATH: Jan. 14, 1967 | 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1700 Meridene Drive

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-38
D. STREET ADDRESS (If rural, give location): 1700 Meridene Dr. (Fenwick Apts.)

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 1-16-1889
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10B. KIND OF BUSINESS OR INDUSTRY: Priting
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. Williams
14. MOTHER'S MAIDEN NAME: Mary Francis Childs

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-10-1433
17. INFORMANT: Dr. Joseph V. Castagna ADDRESS: Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of liver & metastasis — 1 year

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Auricular fibrillation, Emphysema

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 8/6/ 1966 to 1/14 1967, that (I) (~~we~~) last saw the deceased alive on 1/14 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death. 1/14/67 at 5 a.m.

23A. SIGNATURE: Joseph V. Castagna
M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type): Joseph V. Castagna M.D.
23D. ADDRESS: 4316 St. Paul St. Balto. (21218) md

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-67
24C. NAME of CEMETERY or CREMATORY: Zion Lutheran
24D. LOCATION (City, town, or county) (State): Middletown Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fahey M.D.
25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co. ADDRESS: 4905 York Rd. Balto., Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

9500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0441 Registered No. 67 0441

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Christopher Owen Quinn

2. DATE AND HOUR OF DEATH Jan. 14, 1967 4:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-01
D. STREET ADDRESS (If rural, give location) 649 Dumbarton Ave

5. SEX Male
6. RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married
8. DATE OF BIRTH 12/25/03
9. AGE (In years last birthday) 63
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-LABORER
10B. KIND OF BUSINESS OR INDUSTRY MAINT. BALTO. CITY Unknown
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Quinn
14. MOTHER'S MAIDEN NAME Catherine Mahon

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-34-1714
17. INFORMANT Mrs. Margaret E. Quinn ADDRESS Same

MEDICAL CERTIFICATION

1B. 161X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH: 17 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Dec 1965
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Larynx
20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from 12/7 19 66 to 1/14 19 67, that (I) ~~(we)~~ last saw the deceased alive on 1/13 19 67 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) ~~(did not)~~ view the body after death.

23A. SIGNATURE Nat E. Watson, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED 1/14/67
23C. PHYSICIAN'S NAME (Type) DR NAY E. WATSON JR M.D.
23D. ADDRESS THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/17/67
24C. NAME of CEMETERY or CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) Baltimore (State) Md.

25A. DATE REC'D BY HEALTH DEPT. JAN 16 1967
25B. NAME OF REGISTRAR Robert E. Falkenhan
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.
ADDRESS 4905 York Rd. Balto. 12, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-453

BIRTH NO. 67 0442

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0442

1. NAME OF DECEASED (Type or Print): John H. Vaillant

2. DATE AND HOUR OF DEATH: 1/14/67 5:43 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY: Balto. Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Ruxton 53-00

D. STREET ADDRESS (If rural, give location): 1203 Boyce Avenue #4

5. SEX: Male

6. RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 3/29/88

9. AGE (In years last birthday): 78

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Artist

10B. KIND OF BUSINESS OR INDUSTRY: Portrait

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustus Vaillant

14. MOTHER'S MAIDEN NAME: Elizabeth Crotty

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 019-07-0310

17. INFORMANT: Mrs Lena Vaillant

ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) A.S.C.V.D.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Uremia

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1/5 19 67 to 1/14 19 67, that (I) last saw the deceased alive on 1/13 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) view the body after death.

23A. SIGNATURE: Nat E. Watson, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type): DR. NAT E. WATSON JR. M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-17-67

24C. NAME of CEMETERY or CREMATORY: Monte Marie

24D. LOCATION (City, town, or county) (State): Towson Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: R. E. Farber M.D.

25C. FUNERAL DIRECTOR: H.W. Jenkins & Sons Co.

ADDRESS: 4905 York Rd. Balto., Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

G-536

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0443

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0443

1. NAME OF DECEASED (Type or Print): ANNA REBECCA GONTRUM

2. DATE AND HOUR OF DEATH: Jan. 11. 1967 | 12.40 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 Harford Gardens Nursing Home 4700 Harford Rd. Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21218 9-06
D. STREET ADDRESS (If rural, give location): 2705 Hugo Avenue

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Sept. 15. 1877
9. AGE (In years last birthday): 89
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chambersburg, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Lippy
14. MOTHER'S MAIDEN NAME: Anna McKane

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-09-6058
17. INFORMANT: Mrs. Myrtle G. Hogarth (daughter)
ADDRESS: 2705 Hugo Ave. Baltimore 21218

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Arterio-sclerotic cardio vascular disease
DUE TO
(B)
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this ~~hospital~~) attended the deceased from 22 October 1960 to 11 January 1967, that (I) (~~we~~) last saw the deceased alive on 22 December 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: John W. Barnaby M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 12 Jan 67
23C. PHYSICIAN'S NAME (Type): JOHN W. BARNABY M.D.
23D. ADDRESS: 1531 E. North Ave. Baltimore 21213

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 14. 1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Kelly, M.D.
25C. FUNERAL DIRECTOR: HENRY SANDER & SONS. INC.
ADDRESS: Baltimore Md.

VS 150-REV. 1/1/65

H-200

1

BIRTH NO. 67 0444

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0444

1. NAME OF DECEASED (Type or Print): HERBERT CLINTON HAX

2. DATE AND HOUR PRONOUNCED DEAD: January 10, 1967 | 7:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21215 15-11

D. STREET ADDRESS (If rural, give location): 3803 Cederdale Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: Sept. 10. 1895

9. AGE (In years last birthday): 71

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Hax

14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes

(If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 215-01-0643

17. INFORMANT: Mrs. Grace C. Hax (wife)

ADDRESS: 3803 Cedardale Rd. Baltimore 21215

MEDICAL CERTIFICATION

CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH

1B. 443X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R. Breitenecker M.D.

EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/11/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: Jan. 14. 1967

23C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

23D. LOCATION (City, town, or county) (State): Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

24B. NAME OF REGISTRAR: Robert E. Fankey M.D.

24C. FUNERAL DIRECTOR: HENRY SANDER & SONS. INC.

ADDRESS: Baltimore Md.

0 4 4 4

VS 151-REV. 1/1/65

B-621

67 0445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0445

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Eula M. Birche

2. DATE AND HOUR OF DEATH: 1/14/67 | 10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-07

D. STREET ADDRESS (If rural, give location): 300 North Hilton Street

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 7/30/95

9. AGE (In years last birthday): 71

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian

10B. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Northumberland Co.Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Nutt

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Haney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-40-7188

17. INFORMANT: William Meredith Birche Jr.

ADDRESS: 300 N. Hilton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) PROBABLE PULMONARY EMBOLUS — INSTANTANEOUS

DUE TO

(B) PERICARDITIS, ANEMIA, FUO — 2 MONTHS

DUE TO

(C) PROBABLE TUBERCULOSIS

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?: No

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7 1967 to 1/14 1967, that (I) (we) last saw the deceased alive on 1/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allen Johnson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type): Allen Johnson M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/19/1967

24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Rose E. Fantayna

25C. FUNERAL DIRECTOR: Herbert E. Nutter

ADDRESS: 3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0446 Registered No. 67 0446

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Nannie Hill

2. DATE AND HOUR OF DEATH: 1/9/67 | 8 10 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 13-04
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3224 Auchentoroly Terrace

5. SEX	6. RACE	7. MARITAL STATUS (Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Female	Negro	Single	9/12/97	69		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10B. KIND OF BUSINESS OR INDUSTRY: Pvt. Family

11. BIRTHPLACE (State or foreign country): Essex Co. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Hill

14. MOTHER'S MAIDEN NAME: Virginia Ware

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-32-4483

17. INFORMANT: Grace Boston- 119 N. 62nd Street ADDRESS Phila Pa.

MEDICAL CERTIFICATION

18. 422.11

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cardiac & Resp. Arrest — 1 hr

DUE TO

(B) CVA acute — 2 days

DUE TO

(C) Arteriosclerotic CVD — several years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/7 1967 to 1/9 1967, that (I) (we) last saw the deceased alive on 1/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: SW Spaulding M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/9/67

23C. PHYSICIAN'S NAME (Type): S. W. Spaulding M.D.

23D. ADDRESS: Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/12/67	Mount Auburn Cemetery	Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible] E. Fabian

25C. FUNERAL DIRECTOR: Herbert E. Nutter ADDRESS 3035 W. North Ave.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462

BIRTH NO. 67 0447

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0447

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): HARRY CLARK

2. DATE AND HOUR OF DEATH: 1-8-67 5:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

37

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside city limits, write RURAL and township): BALTIMORE, 4-02
D. STREET ADDRESS (If rural, give location): 700 E. Baltimore

5. SEX: M 6. RACE: W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): ? 8. DATE OF BIRTH: 5-20-02 9. AGE (In years last birthday): 64 If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ? 10B. KIND OF BUSINESS OR INDUSTRY: ? 11. BIRTHPLACE (State or foreign country): ? 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? 14. MOTHER'S MAIDEN NAME: ? Ann Bolger

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): 16. SOCIAL SECURITY NO.: 17. INFORMANT: St. Vincent de Paul Society ADDRESS: 320 Cathedral St. Balt. Md.

MEDICAL CERTIFICATION

18. 33 / X / 340.3

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
(A) Septicemia (Proteus)
DUE TO
(B) Meningitis (Proteus)
DUE TO
(C) CVA

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ?

19A. DATE OF OPERATION: 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: — 20A. AUTOPSY? (Yes or No): 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner) — 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — 21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐ — 21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-31-67 19 to 1-8-67 19, that (I) (we) last saw the deceased alive on 1-8-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stephan J. Wittmann M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED: 1-8-67

23C. PHYSICIAN'S NAME (Type): STEPHAN J. WITTMANN M.D. 23D. ADDRESS: MERCY HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial 24B. DATE: 1/13/67 24C. NAME of CEMETERY or CREMATORY: New Cathedral 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967 25B. NAME OF REGISTRAR: [illegible] 25C. FUNERAL DIRECTOR: Wm. Cook-Brooks Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0448 Registered No. 67 0448

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): CECILIA MARIE KNOX

2. DATE AND HOUR OF DEATH: 7:50 PM JAN 13 '67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): USPHS HOSP BALTIMORE

28

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 1024 Newton St

C. CITY OR TOWN (If outside city limits, write RURAL and give township): NE Wash 17, D.C V-48

D. STREET ADDRESS (If rural, give location):

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never Married

8. DATE OF BIRTH: 12/14/99

9. AGE (In years last birthday): 67

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10B. KIND OF BUSINESS OR INDUSTRY: NURSE

11. BIRTHPLACE (State or foreign country): Ill.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH KNOX

14. MOTHER'S MAIDEN NAME: ELIZABETH McCloskey

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): YES (If yes, give war or dates of service): USPHS

16. SOCIAL SECURITY NO.: 230-50-8740

17. INFORMANT: Chart ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

194X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PAPILLARY CARCINOMA THYROID — 1952

DUE TO

(B) PULMONARY METASTASIS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from July 25 19 66 to Jan 13 19 67, that I (we) last saw the deceased alive on Jan 13 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: L Slater MD M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type) M.D.

23D. ADDRESS: c/o USPHS Balt

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/67

24C. NAME of CEMETERY or CREMATORY: St. Mary's Maria Cemetery

24D. LOCATION (City, town, or county) (State): Peoria Ill

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Faulkner

25C. FUNERAL DIRECTOR: Wm Cook-Brook Inc. ADDRESS: 1217 St. Paul St Baltimore 2 Md

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
G140

67 0449

BALTIMORE CITY HEALTH DEPARTMENT

67 0449

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): VENA Gambell GOBLE ~~GOBLE~~

2. DATE AND HOUR PRONOUNCED DEAD: January 15, 1967 | 1:45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED 1-17-67

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-02
D. STREET ADDRESS (If rural, give location): 1022 E. Lombard Street

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Separated
8. DATE OF BIRTH: Apr. 30, 1922
9. AGE (In years last birthday): 44
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): ~~Virginia~~ North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Frank Gambell
14. MOTHER'S MAIDEN NAME: Jannie Casey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No ----------
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mrs. Jannie Higgins, Jessop, Md,
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 490 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty Liver.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? b Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy Partial ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/15/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: Jan. 18, 1967
23C. NAME of CEMETERY or CREMATORY: Prospect Hill Cemetery
23D. LOCATION (City, town, or county) (State): Towson, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: Robert E. Farley M.D.
24C. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.,
ADDRESS: 1217 St. Paul St. Baltimore, Maryland

0418

VS 151-REV. 1/1/65

V.S. 153 1-17-67 M.H.

H-120

67 0450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 67 0450

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): HOBBS CARRIE W.

2. DATE AND HOUR OF DEATH: 12 JAN 1967 9¹⁰ P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: UNION MEMORIAL HOSPITAL BALTIMORE

(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-01

D. STREET ADDRESS (If rural, give location): 3902 SOUTHERN AVENUE

47

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 12-07-~~78~~ 75

9. AGE (In years last birthday): 91

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: ~~NOT KNOWN~~ JOHN F. WILD

14. MOTHER'S MAIDEN NAME: ~~NOT KNOWN~~ REGINA C. DEGRAFF

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: CHARICE M. SHOUK ADDRESS: COCKEYSVILLE Md

CERTIFICATION APPROVED BY: [illegible] M.D. ASST. MEDICAL EXAMINER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

E900.01

(a) PULMONARY EMBOLUS — 2 days

DUE TO

(b) THROMBO PHLEBITIS

DUE TO

(c) FRACTURE of (R) FIBULA — 11 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE — 10-20 YEARS

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner): ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): On bottom step of stairs 27-01

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 12-31-66 7.30 P.M.

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑

21F. HOW DID INJURY OCCUR? Caught foot in house coat + fell to the floor

22. I certify that (I) (this hospital) attended the deceased from 9 JAN 1967 to 12 JAN 1967, that (I) (we) last saw the deceased alive on 12 JAN 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjofur Bjornsson M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 12 JAN '67

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1-14-67

24C. NAME of CEMETERY or CREMATORY: LOUDON

24D. LOCATION (City, town, or county) (State): BALTIMORE. Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: [illegible] Brooks Towson. Towson, Md

ADDRESS

VS 150-REV. 1/1/65 N 823.2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Approved and released by the Medical Examiner 1-13 67

65099 Spring

0-165

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0451 Registered No. 67 0451

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Delia C. O'Brien

2. DATE AND HOUR OF DEATH: Jan. 13, 1967 | 12:55 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2630 N. Calvert St.

48

12-03

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Never married
8. DATE OF BIRTH: 1/6/86
9. AGE (In years last birthday): 81
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): register operator
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John O'Brien
14. MOTHER'S MAIDEN NAME: McCommis

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-10-3591
17. INFORMANT: John O'Brien (Nephew)
ADDRESS: 2607 Gwyndale Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

490X I

(A) Pneumococcal Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Lobar Pneumonia LLL — 4 days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia, etiol unknown

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 11 1967 to Jan 13 1967, that (I) (we) last saw the deceased alive on Jan. 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/13/67
23C. PHYSICIAN'S NAME (Type): W. Michael Gould M.D.
23D. ADDRESS: Maryland General Hosp. Balto. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Talley M.D.
25C. FUNERAL DIRECTOR: Wm. Cook-Brooks F.H.
ADDRESS: 1217 St. Paul St. Baltimore Md. 21202

VS 150-REV. 1/1/65

W 452 1

BIRTH NO. 67 0452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0452

M.E. CASE NO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): Polly Williams

2. DATE AND HOUR OF DEATH: 15 Jan. 1967 8:30 A.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 La Plaza Nursing Home 1515 N. Bruce St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 1606

D. STREET ADDRESS (If rural, give location): 2865 W. Lafayette Ave.

5. SEX: Female

6. RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widow

8. DATE OF BIRTH: Jul. 2, 1889

9. AGE (In years last birthday): 78

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): N.C.,

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jesse Mason

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-09-0396

17. INFORMANT: Daughter ADDRESS: 2865 W. Lafayette Ave.

MEDICAL CERTIFICATION

1B. 443 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial degeneration — 1 month

DUE TO

(B) Cerebral Arterio-sclerosis — 6 months

DUE TO

(C) Hypertensive cardio vascular — 10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-23- 1966 to 1-15- 1967, that (I) (we) last saw the deceased alive on 1-15- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Geo H Pendleton M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): GEO. H. PENDLETON M.D.

23D. ADDRESS: 1723 Druid Hill Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/18/67

24C. NAME of CEMETERY or CREMATORY: Arbutus;

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR:

25C. FUNERAL DIRECTOR: O. C. Wainwright ADDRESS: 2700 Edmondson Av

VS 150-REV. 1/1/65

P-365

BIRTH NO. 67 0453

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0453

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print): JOSEPH PATERNITI

2. DATE AND HOUR OF DEATH: January 14, 1967. 1 P.M. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(If not in hospital or institution, give street address or location): 6023 Old Harford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, 21-07

D. STREET ADDRESS (If rural, give location): 6023 Old Harford Road

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: March 27, 1890.

9. AGE (In years last birthday): 76

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Carmelo Paterniti

14. MOTHER'S MAIDEN NAME: Concetta ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-01-4012

17. INFORMANT: Mrs. Angelina Paterniti

ADDRESS: (Same)

To be Approved By Medical Examiner

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g. heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

APPROVED BY M.D. CHIEF OR ASST. MEDICAL EXAMINER. 1/16/67

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.): —

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to 1/14 19 67 that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: James E. White M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/14/67

23C. PHYSICIAN'S NAME (Type): James E. White M.D.

23D. ADDRESS: 5214 HARFORD RD. BALTO. 21214

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/18/67.

24C. NAME of CEMETERY or CREMATORY: Dulaney Valley Mem. Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Gadsby M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc. Balto. Md. 21214

ADDRESS:

VS 150-REV. 1/1/65

H-43

BIRTH NO. 67 0454

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0451

1. NAME OF DECEASED (Type or Print): Heltzel, Walter Carol, SR.

2. DATE AND HOUR OF DEATH: 5.10 AM. Jan 15. 1966 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MD B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #18 12-01

D. STREET ADDRESS (If rural, give location): 3618 Greenmount Ave.

5. SEX	6. RACE	7. MARITAL STATUS (Married, Never Married, Widowed, Divorced)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
M	White	Married	12-13-95	71		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Tobacco	Md	American

13. FATHER'S NAME: Wiliam Heltzel

14. MOTHER'S MAIDEN NAME: Irene Cockley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-07-2429

17. INFORMANT: Walter C. JR. ADDRESS: 5511 Belair Rd Baltimore, Md 21206

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 493X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10.25 pm Jan 14 19 66 to 5.10 Am Jan 15 19 66, that (I) (we) last saw the deceased alive on 5.10 Am, Jan 15 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Sang Won Song M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: Jan 15/67

23C. PHYSICIAN'S NAME (Type): DR. SANG WON SONG M.D.

23D. ADDRESS: THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/67.	Moreland Memorial Cemetery	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNEAL DIRECTOR	ADDRESS
JAN 16 1967	Robert E. Farley, M.D.	Leonard J. Buck, Inc.	Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-632

BIRTH NO. 67 0455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0455

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Saverio (SAMUEL) CORTESE

2. DATE AND HOUR OF DEATH: JANUARY 14, 1967 | 11:45 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL
36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE #11 12-07
D. STREET ADDRESS (If rural, give location): 426 W. 23rd ST 11

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 1/28/82
9. AGE (In years last birthday): 84
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES CORTESE
14. MOTHER'S MAIDEN NAME: CATHERINE (?)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 717-02-6395
17. INFORMANT: OHART HOSPITAL
ADDRESS

MEDICAL CERTIFICATION

18. 450.01
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CONGESTIVE HEART FAILURE
DUE TO
(B) ATHEROSCLEROSIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from JANUARY 1 19 67 to JANUARY 14 19 67, that (I) (we) last saw the deceased alive on 11:45, JANUARY 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ferdinand C Rodriguez M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/14/67.
23C. PHYSICIAN'S NAME (Type): FERDINAND C. RODRIGUEZ M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/17/67.
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: X Leonard J. Ruck, Inc.
ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0456 Registered No. 67 0456

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Paul Matthew Kachele

2. DATE AND HOUR OF DEATH: Jan. 15, 1967 12:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2618 Roselawn Ave.

00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md. B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-06

D. STREET ADDRESS (If rural, give location): 2618 Roselawn Ave.

5. SEX: male

6. RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): married

8. DATE OF BIRTH: 8-31-1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Welder-

10B. KIND OF BUSINESS OR INDUSTRY: Balto. Transit

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gustav Kachele

14. MOTHER'S MAIDEN NAME: Anna B. Getch

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213059969

17. INFORMANT: Katherine Kachele ADDRESS: same

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — 1 hour

DUE TO

(B) arteriosclerotic cardiovascular disease with hypertension — 8 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 30 1955 to January 15 1967, that (I) (we) last saw the deceased alive on January 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. Allesi M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/15/67

23C. PHYSICIAN'S NAME (Type): E. J. Allesi M.D.

23D. ADDRESS: 6217 Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify): burial

24B. DATE: 1-18-67

24C. NAME of CEMETERY or CREMATORY: Moreland Mem. Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Lawyer

25C. FUNERAL DIRECTOR: Leonard J. Ruck Inc ADDRESS: Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0457 Registered No. 67 0457

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): FIFIELD, BESSIE

2. DATE AND HOUR OF DEATH: 14 JAN 1967 1:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL 44

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 13-07

D. STREET ADDRESS (If rural, give location): 3939 ROLANDVIEW TOWERS-EAST

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 09-05 1899

9. AGE (In years last birthday): 67

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NEWFOUNDLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: ~~[illegible]~~ Edward Snow

14. MOTHER'S MAIDEN NAME: ~~[illegible]~~ Ellen Reddison

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs. Lois Zeller, 1212 Overbrook Rd. #12 ADDRESS

MEDICAL CERTIFICATION

18. 331X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL HEMORRHAGE — 23 DEC 66

DUE TO

(B) HYPERTENSIVE CEREBRO VASCULAR DISEASE — 2 YEARS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 23 DEC 1966 to 14 JAN 1967, that (I) (we) last saw the deceased alive on 14 JAN 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridtjofur Bjornsson M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 14 JAN 1967

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON M.D. Fridtjofur Bjornsson

23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/67.

24C. NAME of CEMETERY or CREMATORY: Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Leonard J. Buck, Inc. Balto. Md.

ADDRESS: 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-356

BIRTH NO. 67 0458

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0458

1. NAME OF DECEASED (Type or Print): MINNIE REBECCA STONER

2. DATE AND HOUR OF DEATH: Jan 13, 1967 | 5 10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE #14 27-01

D. STREET ADDRESS (If rural, give location): 3524 ALSA AVE.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M

8. DATE OF BIRTH: 09-14-91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: CHARLES HOFFMAN

14. MOTHER'S MAIDEN NAME: LOTTIE ALLEN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-14-3461B

17. INFORMANT: Dr. Harvey M. Stoner

ADDRESS: (Same)

MEDICAL CERTIFICATION

1B. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Acute bronchopneumonia

DUE TO

(B) Coronary arteriosclerosis (ASCVD)

DUE TO

(C) Arteriosclerosis, generalized

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

A Hipolito, M.D.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 01-12 1967 to 01-13 1967, that (I) (we) last saw the deceased alive on 01-13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Zoltan Zarday M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): ZOLTAN ZARDAY M.D.

23D. ADDRESS: Union Memorial Hosp. THE UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/67.

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 10 1967

25B. NAME OF REGISTRAR: [illegible]

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

VS 150-REV. 11/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-25d

BIRTH NO. 67 0459

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0459

1. NAME OF DECEASED (Type or Print): Elizabeth R. McCann

2. DATE AND HOUR OF DEATH: Jan 13, 1967 8:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 27-06

D. STREET ADDRESS (If rural, give location): 2822 Christopher Ave

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): widowed

8. DATE OF BIRTH: 1/1/81

9. AGE (In years last birthday): 86

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Matthew O'Donnell

14. MOTHER'S MAIDEN NAME: Bridget McDonald

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-54-3735

17. INFORMANT: Clara O'Donnell (sister)

ADDRESS: 6108 Old Harford Rd

MEDICAL CERTIFICATION

1B. 422.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Bronchopneumonia

DUE TO

(B) pulmonary edema

DUE TO ASCVD

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 11 1967 to Jan 13 1967, that (I) (we) last saw the deceased alive on Jan 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: W. Michael Gould M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): W. Michael Gould M.D.

23D. ADDRESS: Md. General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/67.

24C. NAME of CEMETERY or CREMATORY: Southern Cemetery

24D. LOCATION (City, town, or county) (State): Dublin, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Tarbeyne

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc.

ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0460 Registered No. 67 0460

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MRS. ELLEN J. MILLS

2. DATE AND HOUR OF DEATH: 1-13-67 1:40 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME + HOSP. 100 N. BROADWAY

35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 6-05

D. STREET ADDRESS (If rural, give location): CHURCH HOME + HOSP. 100 N. BROADWAY

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOW

8. DATE OF BIRTH: 11-3-1873

9. AGE (In years last birthday): 93 — If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~UNKNOWN~~ J.H. Barnett

14. MOTHER'S MAIDEN NAME: UNKNOWN Kennedy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: DONALD MILLS ADDRESS: S. BALTO GEN. HOSPITAL

MEDICAL CERTIFICATION

18. 420.1 + E 902.7

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY CHIEF OR ASST. MEDICAL EXAMINER: 1/14/67

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) BRONCHOPNEUMONIA, MYOCARDIAL INFARCTION — BRONCHO – 2 DAYS, MI – 9 DAYS

DUE TO

(B) CORONARY ATHEROSCLEROSIS — MANY YRS (UNDETERMINED)

DUE TO

(C) FRACTURE, INTERTROCHANTERIC (R) (SHOCK, PAIN + BED RIDDEN) — 9 DAYS

(D) CONGESTIVE HEART FAILURE (??)

Fx. INTERTROCHANTERIC R.

19A. DATE OF OPERATION: 1-11-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Fx. INTERTROCHANTERIC (R)

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner): NOTIFIED

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): CHURCH HOME + HOSPITAL (BED)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): CHURCH HOME + HOSP. 100 N. BROADWAY

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): JAN. 4 67

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☑

21F. HOW DID INJURY OCCUR? PATIENT FELL FROM BED

22. I certify that I (this hospital) attended the deceased from 1-4-67 19 to 1-13-67 19, that I (we) last saw the deceased alive on 1-13-67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: Manuel J. Tan M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-13-67

23C. PHYSICIAN'S NAME (Type): MANUEL TAN M.D.

23D. ADDRESS: CHURCH HOME + HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/16/67.

24C. NAME of CEMETERY or CREMATORY: Cedar Hill Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Talley M.D.

25C. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. ADDRESS: Balto. Md. 21214

VS 150-REV. 1/1/65

N 820.0

MEDICAL EXAMINER NOTIFIED Jan. 13, 1967 → TO BE APPROVED BY MEDICAL EXAMINER (MR. MASON)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MANUEL TAN

Panel of Tan

1-13-67

1-4-67

1-13-67

1-13-67

NOT FED

The A 67

CHICKEN HOUSE → HOSPITAL

Patient pets fellow bed

CHICKEN HOUSE → HOSPITAL (Exit)

CHICKEN HOUSE → HOSPITAL

1-11-67

Fr. JOHN TECHNICIAN (B.)

Fr. JOHN TECHNICIAN B.

Conducting Internal Pathway (77)

(STOCK, PMJ ← Bed Bug Bite)

FRACTURE, INTERTROCHANTERIC (B.) 9 days

CORONARY ATHEROSCLEROSIS

Diagnosis

BLEEDING PEPTIC ULCER, ACUTE

NAME - 9 days

Many Vita

DONALD NILES

Hosp. Tan

S. BALITE

MALKOWSKI

Hospital

Medical Ward

Medical Ward

U.S.A.

Hospital

11-3-1973 Q3

Medical Ward

F W

1
W-625

BIRTH NO. 67 0461

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0461

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALLETA V. WORKMAN

2. DATE AND HOUR PRONOUNCED DEAD: January 15, 1967 7:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 42/99 Sinai Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-31
D. STREET ADDRESS (If rural, give location): 4902 Reisterstown Road

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6-16-1935
9. AGE (In years last birthday): 31
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Parsons West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Helmick
14. MOTHER'S MAIDEN NAME: Ora Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Charles F. Workman, 4902 Reisterstown Rd.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 420.0 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: January 16, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1-19-1967
23C. NAME of CEMETERY or CREMATORY: Mt. Zion Cemetery
23D. LOCATION (City, town, or county) (State): Near Parsons West Virginia

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: [illegible]
24C. FUNERAL DIRECTOR: Howard H. Hubbard
ADDRESS: 4107 Wilkens Avenue 29

VS 151-REV. 1/1/65

D-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0462 Registered No. 67 0462

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): RUTH ESTHER DORSEY

2. DATE AND HOUR OF DEATH: JANUARY 15, 1967, 7:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL

36

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 2005
D. STREET ADDRESS (If rural, give location): 439 FURROW ST.

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): M
8. DATE OF BIRTH: 3/9/97
9. AGE (In years last birthday): 69
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN W. ~~XXXXXXXXXXX~~ Nicodemus
14. MOTHER'S MAIDEN NAME: LAURA BROWN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: Mrs. Dorothy D. Zentgraf, 1439 Clairidge Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

203 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIAC FAILURE

DUE TO

(B) MULTIPLE MYELOMA

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ (this hospital) attended the deceased from JAN. 8 19 67 to JAN. 15 19 67, that ~~(I)~~ (we) last saw the deceased alive on 7:30 AM, JAN 15 19 67 and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Ferdinand C. Rodriguez M.D.
Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/15/67
23C. PHYSICIAN'S NAME (Type): FERDINAND C. RODRIGUEZ M.D.
23D. ADDRESS: FRANKLIN SQUARE HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-67
24C. NAME of CEMETERY or CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE RECEIVED BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Falkenhan
25C. FUNERAL DIRECTOR: Howard H. Hubbard
ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0463 Registered No. 67 0463

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH A. FRITZ

2. DATE AND HOUR OF DEATH: January 13, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

42

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21-02

D. STREET ADDRESS (If rural, give location): 1260 Washington Blvd.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 5-26-1881

9. AGE (In years last birthday): 85

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Zimmerman

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: William G. Fritz, 5529 Link Avenue 21227

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

1B. 433.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac arrest — Immediate

DUE TO

(B) Arteriosclerotic cardiovascular disease — 30 years

DUE TO

(C) Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diverticulitis — 1 year

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 13 19 67 to 19 , that (I) (we) last saw the deceased alive on January 13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Donald O Wood M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: January 16, 1967

23C. PHYSICIAN'S NAME (Type): Dr. Donald O. Wood M.D.

23D. ADDRESS: York Rd. & Greenmeadow Drive

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-17-67

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Falkenhan

25C. FUNERAL DIRECTOR: Howard H. Hubbard

ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-41

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0464

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0464

1. NAME OF DECEASED (Type or Print): Gertie GERTRUDE GILBERT

2. DATE AND HOUR OF DEATH: 1-15-67 | 8:55 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00
D. STREET ADDRESS (If rural, give location): 1008 ST. CHARLES AVE

5. SEX: F
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4-1-93
9. AGE (In years last birthday): 73
If Under 1 Yr. Months — Days — If Under 24 Hrs. Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): West VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ramer Williams
14. MOTHER'S MAIDEN NAME: —

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 235-~~36~~-0385
17. INFORMANT: HOSPITAL CHART. ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — 165X
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) METASTATIC CARCINOMA OF LUNG — INTERVAL BETWEEN ONSET AND DEATH: 9 MOS.
DUE TO: —
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD — ?

19A. DATE OF OPERATION: 0 —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: —
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR? —

22. I certify that (I) (this hospital) attended the deceased from 12-23 1966 to 1-15 1967, that (I) (we) last saw the deceased alive on 1-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Alvin Schachter M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1-15-67
23C. PHYSICIAN'S NAME (Type): ALVIN SCHACHTER M.D.
23D. ADDRESS: SINAI HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Farley M.D.
25C. FUNERAL DIRECTOR: Howard H, Hubbard, 4107 Wilkens Avenue 21229 ADDRESS:

VS 150-REV. 1/1/65

F-4516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0465 Registered No. 67 0465

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Tess Moore Fleischer

2. DATE AND HOUR OF DEATH: January 12, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Temple Garden Garden Apartments 2601 Madison Avenue Apt. 1106 Baltimore, Maryland 21217

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): 2601 Madison Ave. Apt. 1106

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: May 2, 1908
9. AGE (In years last birthday): 57
If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Silas Fleischer
14. MOTHER'S MAIDEN NAME: Blanche Mohr

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 212-09-0387
17. INFORMANT: Mr. Samuel J. Fisher
ADDRESS: 1355 Md. Nat'l Bk. Blg.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis — ORIGINALLY OPERATED 5 YRS. AGO —

DUE TO

(B) (primary colon)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from July 1962 to DEATH 19..., that (I) (~~we~~) last saw the deceased alive on Jan. 9 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Carlton L. Sexton M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: Jan. 12, 1967

23C. PHYSICIAN'S NAME (Type): Carlton L. Sexton, M.D.
23D. ADDRESS: 819 Park Avenue, Baltimore, Md. 21201

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/13/1967
24C. NAME of CEMETERY or CREMATORY: Baltimore Hebrew Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Wm. J. Tilman & Sons
ADDRESS: Balto. Md. [illegible]

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-15 L

BIRTH NO. 67 0466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0466

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mildred D. Heffner

2. DATE AND HOUR OF DEATH: January 12, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 935 East 41st. Street Baltimore, Maryland 21218
00

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 9-01
D. STREET ADDRESS (If rural, give location): 935 East 41st. Street 18

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 1/13/1905
9. AGE (In years last birthday): 61
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Secretary
10B. KIND OF BUSINESS OR INDUSTRY: H K and Company
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Norval F. Davis
14. MOTHER'S MAIDEN NAME: Nettie M. Taylor

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-32-9618
17. INFORMANT: Mr. Albert S. Heffner
ADDRESS: same address

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 174 X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GENERALIZED METASTASES — 4 MOS
DUE TO
(B) PAPILLARY ADENOCARCINOMA - UTERUS — 2 YEARS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8/4 1964 to 1/12 1967, that (I) (we) last saw the deceased alive on ____ 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: R. B. Tunney M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/12/67
23C. PHYSICIAN'S NAME (Type): R. B. TUNNEY M.D.
23D. ADDRESS: 7215 YORK RD BALTO MD.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/1967
24C. NAME of CEMETERY or CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Louis E. Faherma
25C. FUNERAL DIRECTOR: Wm. J. Pichna & Sons
ADDRESS: Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0467 Registered No. 67 0467

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Sallie G. Dorsey

2. DATE AND HOUR OF DEATH: January 13, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 90 3939 Penhurst Avenue Baltimore, Maryland 21215

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3913 Liberty Heights Avenue 21207

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: April 17, 1876
9. AGE (In years last birthday): 90
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor - Retired
10B. KIND OF BUSINESS OR INDUSTRY: Jacob's Clothing
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joshual Glenn
14. MOTHER'S MAIDEN NAME: Laura Morris

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 212-16-5606 A
17. INFORMANT: Mr. Jessie Klair ADDRESS: 1301 Crofton Road

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1B. 443X

(A) Infirmities of Age
DUE TO
(B) Generalized Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.: Hypertension C.V. Disease

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan 1944 19 to Jan 13-67 19, that (I) (we) last saw the deceased alive on Jan 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Nathan G. Atkins M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1-14-67
23C. PHYSICIAN'S NAME (Type) M.D.
23D. ADDRESS: 450 Liberty Heights

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/1967
24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Lawley, M.D.
25C. FUNERAL DIRECTOR: Wm. J. Fuhrman & Sons ADDRESS: Baltimore, Md. North 2 Pa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-400

BIRTH NO. 67 0468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0468

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Gertrude Coll

2. DATE AND HOUR OF DEATH: January 12, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): House in the Pines - Belvedere, 2525 West Belvedere Avenue, Baltimore, Maryland 21215

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Falls Church
D. STREET ADDRESS (If rural, give location): 1903 Pimmit Drive

V-43

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: March 3, 1879
9. AGE (In years last birthday): 87
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Music Teacher - self
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Robert Duncan
14. MOTHER'S MAIDEN NAME: Margaret Malloy

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Miss Blanche Coll
ADDRESS: 1805 Queens Lane Apt. 145 Falls Church, Va. 22201

MEDICAL CERTIFICATION

18. 260 X

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Pneumonia — 1 day

DUE TO

(B) Decubitis Ulcers — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?:

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov 13 1965 to Jan 12 1967, that (I) (we) last saw the deceased alive on Jan 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Lester N. Kolman M.D.
Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): LESTER N. KOLMAN, M.D. M.D.
23D. ADDRESS: 3700 Park Heights Ave. 21215

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/16/1967
24C. NAME of CEMETERY or CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Parker M.D.
25C. FUNERAL DIRECTOR: Wm. J. Trimmer & Sons
ADDRESS: Balto. 1 not with 2 Sa.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1
C-552

67 0469

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0469

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Edwin L. Cunningham

2. DATE AND HOUR PRONOUNCED DEAD: 1/9/67 10:08 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 210 W. 25th St.

5. SEX: male
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: Jan. 6, 1900
9. AGE (In years last birthday): 67
If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Chauffer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William C. Cunningham
14. MOTHER'S MAIDEN NAME: Mary E.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 248-05-1437
17. INFORMANT: Mrs. Jacquline Slouck
ADDRESS: 708 St. Dunstans Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 570.3

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fibrinous peritonitis

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Strangulation of small bowel following adhesions

~~DUE TO~~

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION: 2
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/10/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial
23B. DATE: 1/14/1967
23C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
23D. LOCATION (City, town, or county) (State): Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
24B. NAME OF REGISTRAR: Robert E. Fahey M.D.
24C. FUNERAL DIRECTOR: Wm. J. Zirkman & Sons
ADDRESS: Balto., Md. north of Pa.

VS 151-REV. 1/1/65

0130

BIRTH NO. 67 0470

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0470

1. NAME OF DECEASED (Type or Print): J. William Offutt

2. DATE AND HOUR OF DEATH: Jan. 12, 1967 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 40 St. Agnes Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 20-07

D. STREET ADDRESS (If rural, give location): 169 S. Morley St.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: ~~Mo~~ May 9, 1892

9. AGE (In years last birthday): 74

If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (Office)

10B. KIND OF BUSINESS OR INDUSTRY: Cemetery

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: J. William Offutt

14. MOTHER'S MAIDEN NAME: Frances Bauer

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes

(If yes, give war or dates of service): 1918

16. SOCIAL SECURITY NO.: 215-09-1995A

17. INFORMANT: Mrs. Nellie F. Offutt

ADDRESS: 169 S. Morley St. Balto. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dehydration + Malnutrition

DUE TO

(B) Chronic urinary tract infection

DUE TO

(C) Paralysis of left side due to Cerebral Vascular Accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1966 to 12 Jan 1967, that (I) (we) last saw the deceased alive on 12 Jan. 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: William J. Bryson M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 13 Jan 67

23C. PHYSICIAN'S NAME (Type): William S. Bryson M.D.

23D. ADDRESS: 4605 Edmondson Ave Balto. 29

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 16, 1967

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: R. S. Tillman

25C. FUNERAL DIRECTOR: G. Truman Schwab

ADDRESS: 3512 Frederick Ave/Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-34-38 ED

S-400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0471 Registered No. 67 0471

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT SEELEY

2. DATE AND HOUR OF DEATH: 13 January 1967 | 6:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
4940 Eastern Ave.
Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): CATONSVILLE
D. STREET ADDRESS (If rural, give location): 80 North Prospect Ave. 21228 005

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married
8. DATE OF BIRTH: 6/25/86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager Apt. House
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Seeley
14. MOTHER'S MAIDEN NAME: Ida ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 225-05-2805
17. INFORMANT: BCH: Records 4940 Eastern Ave. Baltimore, Md.
ADDRESS # 21224

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiorespiratory Collapse — hours
DUE TO
(B) Gram negative sepsis. — days
DUE TO
(C) multiple decubiti, U.T.I. — weeks
CVA, senility confusion

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): no
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Dec 20 1967 to Jan 13 1967, that (I) (~~we~~) last saw the deceased alive on Jan 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Alan J. Barnes M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 13 Jan. 1967
23C. PHYSICIAN'S NAME (Type): ALAN J. BARNES M.D.
23D. ADDRESS: 4940 Eastern Ave. Baltimore, Md. # 21224

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16, 1967
24C. NAME of CEMETERY or CREMATORY: Cedar Bluff Cem.
24D. LOCATION (City, town, or county) (State): Annapolis, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: G. Truman Schwab
ADDRESS: 3512 Frederick Ave. Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-36

BIRTH NO. 67 0472

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0472

1. NAME OF DECEASED (Type or Print): Sturgill, Alma

2. DATE AND HOUR OF DEATH: 1/13/67 | 10:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL

33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: CARROLL Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): WESTMINSTER 56-27

D. STREET ADDRESS (If rural, give location): ~~84~~ COURT STREET

5. SEX: FEMALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED

8. DATE OF BIRTH: 1-27-17

9. AGE (In years last birthday): 49

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~ADAM~~ John King

14. MOTHER'S MAIDEN NAME: IDA Keatley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Luay Johnson ADDRESS: Woodbridge Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

		INTERVAL BETWEEN ONSET AND DEATH
1. 491 X 4 008.1		
(A)	Klebsiella Pneumonia	4 days
DUE TO (B)	Aspiration Pneumonia	12 hr.
DUE TO (C)	Chronic alcoholism n	many yrs.
	Urinary Tract Infection	4 days.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Suspect Tuberculosis.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/9 19 67 to 1/13 19 67, that (I) (we) last saw the deceased alive on 1/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C.H. Brown, III M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): C.H. Brown, III M.D.

23D. ADDRESS: Johns Hopkins Hospital.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/16/67

24C. NAME of CEMETERY or CREMATORY: Evergreen Memorial

24D. LOCATION (City, town, or county) (State): Finksburg, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: D. F. Eline & Sons ADDRESS: Reisterstown, Md.

VS 150-REV. 1/1/65

THE BODY OF ALMA STURGILL WAS RELEASED BY DR. PETTY OF THE CHICAL EXAMINERS OFFICE AS NON MEDICAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

6-232

67 0473

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0473

1. NAME OF DECEASED (Type or Print): JOSEPH OSTASEWSKI

2. DATE AND HOUR PRONOUNCED DEAD: January 11, 1967 9:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 36 Franklin Square Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-43

D. STREET ADDRESS (If rural, give location): 1637 Spence Street #30

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 2/12/1916

9. AGE (In years last birthday): 50

If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector

10B. KIND OF BUSINESS OR INDUSTRY: Baltimore City

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Ostasewski

14. MOTHER'S MAIDEN NAME: Mary Wyrostek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 217-03-8200

17. INFORMANT: Jeanette Ostasewski (nee Brinegar), wife, above

ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH

I

1B. 420.0

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: January 12, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1/16/67

23C. NAME of CEMETERY or CREMATORY: Baltimore National Cemetery

23D. LOCATION (City, town, or county) (State): Maryland

24A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967

24B. NAME OF REGISTRAR: Robert E. Farley M.D.

24C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.

ADDRESS: 3331 Brehms Lane #13

VS 151-REV. 1/1/65

1967 0 0 0 4 7 3

W-200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0474 Registered No. 67 0474

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WISE, HELEN C.

2. DATE AND HOUR OF DEATH: January 11, 1967 | 9 am M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1449 Medfield Road Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-02
D. STREET ADDRESS (If rural, give location): 416 N. Glover Street #24

5. SEX: female
6. RACE: white
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH: 12/8/08
9. AGE (In years last birthday): 58 yrs.
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George A. Miller
14. MOTHER'S MAIDEN NAME: Katherine Glose

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Raymond Wise, husband, above
ADDRESS:

MEDICAL CERTIFICATION

1B. 410X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute congestive failure DUE TO
Rheumatic heart disease with mitral stenosis
(B) DUE TO Acute auricular fibrillation
(C) Mental depression with severe malnutrition

INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Skin tumor, left ear

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 1961 to Jan. 11 1967, that (I) (~~we~~) last saw the deceased alive on Dec. 25 1966 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature], M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/11/67
23C. PHYSICIAN'S NAME (Type): Dr. Fromm M.D.
23D. ADDRESS: 8014 Old Harford Road

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 16 1967
25B. NAME OF REGISTRAR: Robert E. Farley, M.D.
25C. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 3301 Brehms Lane #13

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-1521

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0475

M.E. CASE NO. EDWARD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0475

1. NAME OF DECEASED (Type or Print): Charles Robinson

2. DATE AND HOUR OF DEATH: 1-13-67 | 10:20 A.M.

CERTIFICATE AMENDED

1-24-67

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore, H2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3830 Dolfield Ave.

5. SEX: M
6. RACE: N
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: 12/15/1895
9. AGE (In years last birthday): 71
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Garage Owner
10B. KIND OF BUSINESS OR INDUSTRY: auto repairs
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John H. Robinson
14. MOTHER'S MAIDEN NAME: Nettie Kelly

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-34-1977
17. INFORMANT: Joseph Burroughs, 3830 Dolfield Ave — ADDRESS

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 610 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal Failure — ?
DUE TO
(B) Obstructive Uropathy
DUE TO
(C) Prostatic Enlargment

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-12 19 67 to 1-13 19 67, that (I) (we) last saw the deceased alive on 1-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Allan S. Rudolph M.D. — Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1-13-67
23C. PHYSICIAN'S NAME (Type): Allan S. Rudolph M.D.
23D. ADDRESS: Sinai Hospital

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-19-67
24C. NAME of CEMETERY or CREMATORY: Laurel Hill Baptist Cemetery
24D. LOCATION (City, town, or county) (State): Louisa, Louisa Co. Va.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fabian
25C. FUNERAL DIRECTOR: John M. Johnson — ADDRESS: 1700 Druid Hill Ave.

VS 150-REV. 1/1/65

1/24/67 - Insurance Policy from The Baltimore Insurance Company, Balti more, Md.

for Charles Edward Robinson. Insured: 3/4/1935. Age next birthday: 41.

Policy No. 2514110. J B Carter

1
L-250

BIRTH NO. 67 0476

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 67 0476

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Dorothy Lawson

2. DATE AND HOUR PRONOUNCED DEAD: 1/3/67 8:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION: 00

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 434 Bloom St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03

D. STREET ADDRESS (If rural, give location): 434 Bloom St.

5. SEX: female

6. RACE: colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widow

8. DATE OF BIRTH: 8-4-1936

9. AGE (In years last birthday): 30

If Under 1 Yr. Months | Days | Hours | If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Lawson

14. MOTHER'S MAIDEN NAME: Martha Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ronald Ford

ADDRESS: 1924 McCulloh St.

MEDICAL CERTIFICATION

18. 581.0

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH: Fatty alteration of liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED: 1/3/67

23A. BURIAL CREMATION, REMOVAL (Specify): Burial

23B. DATE: 1-10-67

23C. NAME of CEMETERY or CREMATORY: Mt Calvary

23D. LOCATION (City, town, or county) (State): Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

24B. NAME OF REGISTRAR: R. Paul E. Fackenthal

24C. FUNERAL DIRECTOR: Pennell & Oden

ADDRESS: Balto. Md.

VS 151-REV. 1/1/65

D-325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0477 Registered No. 67 0477

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): MARTHA JANE OREM DOTSON

2. DATE AND HOUR OF DEATH: 1-9-67 - 11:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LA Plaza Nursing Home 1515 Bruce St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-02

D. STREET ADDRESS (If rural, give location): 1515 Bruce St

5. SEX: Fe

6. RACE: Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): W

8. DATE OF BIRTH: 1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): —

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Priscilla Sommerville

ADDRESS: 1515 Bruce St

MEDICAL CERTIFICATION

1B. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH / INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial degeneration — 30 days

DUE TO

(B) Cerebral arteriosclerosis — 60 days

DUE TO

(C) Hypertension — 90 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-21- 1966 to 1-9- 1967, that (I) (we) last saw the deceased alive on 1-9- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED:

23C. PHYSICIAN'S NAME (Type): GEO H. PENDLETON M.D.

23D. ADDRESS: 1723 Druid Hill Ave

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-17-67

24C. NAME of CEMETERY or CREMATORY: Mt Calvary

24D. LOCATION (City, town, or county) (State): Brooklyn A.A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahrney

25C. FUNERAL DIRECTOR: Harrell & Odem

ADDRESS: Balto. Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-220

3830 4455 SAKOWSKI, JAMES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 0478

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0478

1. NAME OF DECEASED (Type or Print): James Sakowski

2. DATE AND HOUR OF DEATH: 1/4/67 | 8:30 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 2-03
D. STREET ADDRESS (If rural, give location): 1617 Lancaster Street

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 61years old 1/29/05
9. AGE (In years last birthday): If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMAN
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter
14. MOTHER'S MAIDEN NAME: Anna Wittofski

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MRS. MARGARET BANASHAK, ADDRESS: 525 47th ST.

CAUSE OF DEATH

1B. 540.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO: Cardiac Arrest + Hypertension

(B) DUE TO: Perforated Peptic ulcer

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ?OD MI, Chronic Lung Disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION: 12/31/66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Perf Viscus
20A. AUTOPSY? (Yes or No): YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner): NO
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 12/31/1966 to 1/4/1967, that (I) (~~we~~) last saw the deceased alive on 1/4/1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Fremont P. Wirth Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/4/67
23C. PHYSICIAN'S NAME (Type): Fremont P. Wirth, Jr. M.D.
23D. ADDRESS: The Johns Hopkins Hospital.

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-16-67
24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fabiano
25C. FUNERAL DIRECTOR: Nicholas T. Matthews, ADDRESS: 3021 EASTERN AVE.

VS 150-REV. 1/1/65

M-601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0479 Registered No. 67 0479

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Mary O. Moore

2. DATE AND HOUR OF DEATH: 1-15-67 1:10 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 1426 Presstman Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-01

D. STREET ADDRESS (If rural, give location): 1426 Presstman St.

5. SEX: Female

6. RACE: Negroid

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 2-22-91

9. AGE (In years last birthday): 75

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Carter

14. MOTHER'S MAIDEN NAME:

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212323995

17. INFORMANT: Raymond Moore ADDRESS: 311 N. Carrollton Ave

MEDICAL CERTIFICATION

1B. 334 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Cerebral Arterio sclerosis — 2½ years

DUE TO

(B) Hypertension — 2½ years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-23 1964 to 1-15 1967, that (I) (we) last saw the deceased alive on 1-14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Samuel R. Owings, Jr., M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1-16-67

23C. PHYSICIAN'S NAME (Type): SAMUEL R. OWINGS, JR. M.D.

23D. ADDRESS: 909 N. Carey St. Balto., Md 21217

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-18-67

24C. NAME of CEMETERY or CREMATORY: New Catheral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Tarbyna

25C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

5-53b

BIRTH NO. 67 0480

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0480

1. NAME OF DECEASED (Type or Print): Hattie Smith

2. DATE AND HOUR OF DEATH: 1-14-67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00 2809 Chelsea Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 15-38
D. STREET ADDRESS (If rural, give location): 2809 Chelsea Terrace

5. SEX: Female
6. RACE: Negroid
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed
8. DATE OF BIRTH: 3-3-86
9. AGE (In years last birthday): 80
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Smith
14. MOTHER'S MAIDEN NAME: Julia Scott

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 368123164
17. INFORMANT: Alice Williams ADDRESS: 2809 Chelsea Terrace

MEDICAL CERTIFICATION

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Myocardial Infarct — 24 hrs

DUE TO

(B) Cellulitis of the leg — 2 wks.

DUE TO

(C) Diabetes Mellitus — 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from Sept. 1964 to Jan 15 1967, that (I) (~~we~~) last saw the deceased alive on Jan 15 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (did) (did not) view the body after death.

23A. SIGNATURE: Joshua R. Mitchell III M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 16 Jan 67
23C. PHYSICIAN'S NAME (Type): Joshua R. Mitchell II M.D.
23D. ADDRESS: 2202 Garrison Blvd. Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-18-67
24C. NAME of CEMETERY or CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks
25C. FUNERAL DIRECTOR: George Kelson ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

48-42-46 ED

5-390

BIRTH NO. 67 0481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0481

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Melvin Scott

2. DATE AND HOUR OF DEATH: 1-15-67 8:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore Ctiy Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 21223 007 18-02
D. STREET ADDRESS (If rural, give location): 1136 W. Lexington St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	Negro	Married	6/10/21	45		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Quitman~~ Whitman Scott

14. MOTHER'S MAIDEN NAME: Ida Jenkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217189510

17. INFORMANT: Rose Scott-wife-same ADDRESS # 21224
BCH: Records 4940 Eastern Ave. Baltimore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 11 mo
DUE TO
Poorly differentiated bronchogenic

(B)
DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-3 1967 to 1-15 1967, that (I) (we) last saw the deceased alive on 1-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Richard L. Bishop M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-15-67

23C. PHYSICIAN'S NAME (Type): Richard L. Bishop M.D.

23D. ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. # 21224

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1-19-67	Mt. Auburn Cemetery	Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Fahey M.D.

25C. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1348 N. Calhoun St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-500

BIRTH NO. 53-35-61 A4E3

M.E. CASE NO. 67 0482

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 0482

1. NAME OF DECEASED (Type or Print): RYAN, HILDA M.

2. DATE AND HOUR OF DEATH: Jan. 14 '67 | 5:15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 53-00
D. STREET ADDRESS (If rural, give location): Owings Mills, 21117

5. SEX: F
6. RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 02-14-02
9. AGE (In years last birthday): 64
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Charles T. Carrick
14. MOTHER'S MAIDEN NAME: Rhoda Shoul

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
If yes, give war or dates of service: -
16. SOCIAL SECURITY NO.: 217-24-5908
17. INFORMANT: Thomas E Ryan
ADDRESS: Baublitz Rd RFD Owings Mills Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Bronchopneumonia
DUE TO
(B) Metastatic thyroid CA with tracheal
DUE TO
(C) compression & vol infiltration into bld vessel

A. Hypolito, M.D.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct. 29 '65
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Thyroid Cancer
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Jan. 10 19 67 to Jan 14 19 67, that (I) (we) last saw the deceased alive on Jan. 14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (~~did not~~) view the body after death.

23A. SIGNATURE: Sun Young Choi M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: Jan. 14 '67
23C. PHYSICIAN'S NAME (Print): DR. SUM YOUNG CHOI M.D.
23D. ADDRESS: THE UNION MEMORIAL HOSPITAL Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/18-1967
24C. NAME of CEMETERY or CREMATORY: Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: R. E. Fahrner
25C. FUNERAL DIRECTOR: Frank H. Kertz
ADDRESS: 814 W 36th St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0483 Registered No. 67 0483

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Miss Edna N. Muller

2. DATE AND HOUR OF DEATH: Jan. 14, 1967 | 10:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): KESWICK 700-W-40-St.

91

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: (Balto. City)
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Maryland 13-07
D. STREET ADDRESS (If rural, give location): 700-W-40th-St. 21211

5. SEX: F
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Apr. 29, 1887
9. AGE (In years last birthday): 79
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ? ? ?
10B. KIND OF BUSINESS OR INDUSTRY: ? ? ?
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry E. Muller
14. MOTHER'S MAIDEN NAME: Alice Mahaney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-44-4849
17. INFORMANT: T Mary DiPaula, R. N. ADDRESS: (Keswick)

MEDICAL CERTIFICATION

18. 442X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Arteriosclerotic cardiovascular renal disease — years
DUE TO
Terminal uremia (anuria) — 72 hrs
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from August 1966 to 14 Jan. 1967, that (I) (we) last saw the deceased alive on 14 Jan. 1967 and that in (my) (our) opinion death accurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold P. Biehl M.D. Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 15 Jan 67
23C. PHYSICIAN'S NAME (Type): Harold P. Biehl M.D.
23D. ADDRESS: 700 W. 40th. Street, Balto. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): burial
24B. DATE: Jan-17-67
24C. NAME of CEMETERY or CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): 3801-Frederick-Av 21229

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Tarbey, MD
25C. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108-W-North-Av. 21201

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-340

BIRTH NO. 67 0484

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. X 67 0484

1. NAME OF DECEASED (Type or Print): WILLIAM C. RIEDEL

2. DATE AND HOUR PRONOUNCED DEAD: January 13, 1967 9:55 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): St. Agnes Hospital

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY: Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 53-00

D. STREET ADDRESS (If rural, give location): 1738 Selma Avenue

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	March 15, 1915	51		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Florist	Florist	Maryland	U.S.A.

13. FATHER'S NAME: William Riedel

14. MOTHER'S MAIDEN NAME: Elsie Reinhardt.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		213-05-8557	Catherine C. Riedel	1728 Selma Ave.

MEDICAL CERTIFICATION

CAUSE OF DEATH

1B. E 816.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1-11-67	Splenic lacerations	Yes	Yes

21A. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): near Carville Avenue and Elm Road, Baltimore County 53-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour): 1-11-67 6:48 P m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Driver of truck which hit parked car, then tree.

22. I certify that I held on Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Charles S. Springate M.D.

EXAMINER'S NAME (Type): Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
ASSOCIATE MEDICAL EXAMINER [ ]

DATE SIGNED: January 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME of CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Burial	1/16/67	Meadowridge Cemetery	Dorsey, Howard, Maryland

24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR	ADDRESS
JAN 17 1967	Robert E. Fahrney	Ambrose Inc	1328 Sulphur Sp. Rd.

VS 151-REV. 1/1/65

N 8692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. W-93456 67 0485 | M.E. CASE NO. | Registered No. 67 0485

1. NAME OF DECEASED (Type or Print): Nassrie, Kelley I

2. DATE AND HOUR OF DEATH: Jan. 14, 1967 | 1:45 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): THE JOHNS HOPKINS HOSPITAL 33

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-03
D. STREET ADDRESS (If rural, give location): 3575 JUNEWAY

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): NEVER MARRIED
8. DATE OF BIRTH: 10-31-66
9. AGE (In years last birthday): If Under 1 Yr. Months: 2 Days: 14 | If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: JOHNNIE NASSRIE
14. MOTHER'S MAIDEN NAME: BARBARA MOSKO
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Barbara Nassrie, mother, above | ADDRESS:

MEDICAL CERTIFICATION

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) — CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Congenital Aortic Valvular Stenosis

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: Charles J. Pitt, CHIEF OR ASST. MEDICAL EXAMINER 1/14/67

19A. DATE OF OPERATION: 1/14/67
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: Aortic Stenosis
20A. AUTOPSY? (Yes or No): yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 1/13/67 19 to 1/14/67 19, that I (we) last saw the deceased alive on 1/14/67 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.

23A. SIGNATURE: H. L. Gertner, Jr. M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑
23B. DATE SIGNED: 1/14/67
23C. PHYSICIAN'S NAME (Type): H.L. GERTNER, JR. M.D.
23D. ADDRESS: THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1/14/67
24C. NAME of CEMETERY or CREMATORY: Holy Redeemer Cem
24D. LOCATION (City, town, or county) (State): Belair Rd. Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: R. E. Fahey
25C. FUNERAL DIRECTOR: Schumacher Funeral Home
ADDRESS: 3331 Brehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Approval by Med Examiner Dr Pitt

K-540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0486 Registered No. 67 0486

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): IDA Kemp

2. DATE AND HOUR OF DEATH: January 14, 1967 1:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp. 37 BALTO. MD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 26-05
D. STREET ADDRESS (If rural, give location): 416 Folcroft Street

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	Days	If Under 24 Hrs. Hours	Min.
M	W	Widowed	12/16/88	78				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	at home	BALTO. MD	U.S.A

13. FATHER'S NAME: John Brick

14. MOTHER'S MAIDEN NAME: unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-09-2296B

17. INFORMANT: Lillian Mathison, dght, above ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Acute Myocardial Infarction — Days
DUE TO
(B) Arteria Sclerotic Cardio Vascular Disease — Years
DUE TO
(C) Congestive Heart Fail. — Days

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 5 1967 to January 14 1967, that (I) (we) last saw the deceased alive on January 14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: John G. Green M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: Jan 14, 1967

23C. PHYSICIAN'S NAME (Type): John G. Green M.D.

23D. ADDRESS:

24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	1/18/67	Gardens of Faith Cem.	Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
JAN 17 1967	Robert E. Farley, M.D.	Schlunek Funeral Home, Inc.	3331 Krehms Lane

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-531

BIRTH NO. 67 0487

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0487

1. NAME OF DECEASED (Type or Print): John T. Schmitz

2. DATE AND HOUR OF DEATH: 1-13-67 | 5 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of The Poor 1200 Valley St. Baltimore MD. 21202

90

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

5. SEX: M
6. RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify):
8. DATE OF BIRTH: 2-9-1877
9. AGE (In years last birthday): 89
If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Coast Guard
11. BIRTHPLACE (State or foreign country): Baltimore MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Schmitz
14. MOTHER'S MAIDEN NAME: Catherine Pil

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-52-7992
17. INFORMANT: Little Sis. of The Poor
ADDRESS: 1200 Valley St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

1B. 422.1

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) Pulmonary edema
DUE TO
(B) A. S. C. V.
DUE TO
(C) Generalized arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1966 to Jan 13 1967, that (I) (we) last saw the deceased alive on Jan 13 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Stanley Anklidas M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED: 1/16/67
23C. PHYSICIAN'S NAME (Type): Stanley Anklidas M.D.
23D. ADDRESS: 1101 Maiden Choice Lane Balt. Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 16, 1967
24C. NAME of CEMETERY or CREMATORY: Holy Cross Cemetery
24D. LOCATION (City, town, or county) (State): Ritchie Hgwy., A.A.Co., Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: George J. Gonce
ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4b

BIRTH NO. 67 0488

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

Registered No. 67 0488

1. NAME OF DECEASED (Type or Print): BULLICK, ADOLPH NMI (Adolph F. Bullick)

2. DATE AND HOUR OF DEATH: 1/12/67 2:50 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Veterans Administration Hospital, 3900 Loch Raven Boulevard, Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: A.A.Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore, Glen Burnie 52-00
D. STREET ADDRESS (If rural, give location): 126 Louise Terrace

5. SEX: Male
6. RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Divorced
8. DATE OF BIRTH: 2/17/89
9. AGE (In years last birthday): 77
If Under 1 Yr. Months / Days / If Under 24 Hrs. Hours / Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bullock
14. MOTHER'S MAIDEN NAME: Julie Hine

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 9/18/17 - 6/10/19
16. SOCIAL SECURITY NO.: 521-26-56-35
17. INFORMANT: VA Records, Baltimore, Maryland 21218
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 465 X

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Pulmonary Emboli — 1 week

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): Yes
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 7th 19 67 to January 12th 19 67, that (I) (we) last saw the deceased alive on January 12th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Barry N. Rosenbaum M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: JANUARY 13, 1967
23C. PHYSICIAN'S NAME (Type): BARRY N. ROSENBAUM M.D.
23D. ADDRESS: VA Hospital Baltimore, Maryland 21218

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-1967
24C. NAME of CEMETERY or CREMATORY: Arlington National Cemetery
24D. LOCATION (City, town, or county) (State): Arlington, Virginia

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fahrney
25C. FUNERAL DIRECTOR: George Gonce Funeral Home
ADDRESS: 4001 Ritchie Highway Baltimore, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-5 23

BIRTH NO. 67 0489

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0489

1. NAME OF DECEASED (Type or Print): Odessa N. Knight.

2. DATE AND HOUR OF DEATH: 1-12-1967 | 3:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

43

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland

B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore #21225 25-04

D. STREET ADDRESS (If rural, give location): 3605 Brooklyn Ave.

5. SEX: F

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Married.

8. DATE OF BIRTH: 1-26-15

9. AGE (In years last birthday): 51

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tenn.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Amos Nicholson

14. MOTHER'S MAIDEN NAME: Izzie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 409-24-6013

17. INFORMANT: Joe Edward Knight - same

ADDRESS:

MEDICAL CERTIFICATION

18. 443X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) CEREBRAL VASCULAR HEMORRHAGE — 1 YEAR

DUE TO OLD, AND RECENT — 1 MONTH

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE — SEVERAL YEARS

DUE TO WITH UNILATERAL RENAL ARTERY DISEASE

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-31 19 66 to 1-12 19 67, that (I) (we) last saw the deceased alive on 1-12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harold A. Burnham M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1-12-67.

23C. PHYSICIAN'S NAME (Type): Harold A. Burnham M.D.

23D. ADDRESS: 1213 Light St.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 16, 67

24C. NAME of CEMETERY or CREMATORY: Nicholson Family Cemetery

24D. LOCATION (City, town, or county) (State): Henrietta, Tenn.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Walter E. Lankford

25C. FUNERAL DIRECTOR: George J. Gance

ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 67 0490 Registered No. 67 0490

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Eileen Rose Brough

2. DATE AND HOUR OF DEATH: January 15, 1967 | M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4000 Fourth St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY: 9.9.Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore - 21225 52-00

D. STREET ADDRESS (If rural, give location): 400 Fourth Street

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): Never married

8. DATE OF BIRTH: Aug. 24, 1916

9. AGE (In years last birthday): 50

If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chicago, Ill

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Brough

14. MOTHER'S MAIDEN NAME: Mary Grant

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Grant Brough

ADDRESS: 4000 Fourth St., Baltimore 25,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) Cerebral Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No):

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (~~this hospital~~) attended the deceased from 1954 19 to Jan 14 1967, that (I) (~~we~~) last saw the deceased alive on 1/14 1967 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (~~did~~) (did not) view the body after death.

23A. SIGNATURE: Lester Lebo M.D. Attending Phys. ✓ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: Jan. 16, 1967

23C. PHYSICIAN'S NAME (Type): LESTER LEBO M.D.

23D. ADDRESS: 1801 Eutaw Place, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 17, 1967

24C. NAME of CEMETERY or CREMATORY: New Cathedral Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Tarbert, M.D.

25C. FUNERAL DIRECTOR: George J. Gonce

ADDRESS: 4001 Ritchie Hgwy., Baltimore

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

N-552

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH No. 67 0491 Registered No. 67 0491

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ANNA A. NUNNINGER

2. DATE AND HOUR PRONOUNCED DEAD: January 12, 1967 9:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): 00 1623 Belt Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04
D. STREET ADDRESS (If rural, give location): 1623 Belt Street

5. SEX: Female
6. RACE: White
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): WIDOWED
8. DATE OF BIRTH: JAN. 23, 1885
9. AGE (In years last birthday): 81 YR
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): JERSEY CITY, N.J.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: HENRY REHMKE
14. MOTHER'S MAIDEN NAME: AUGUSTA KILES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. ANNA V. PEARSON ADDRESS: 1623 BELT ST.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No): No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐
DATE SIGNED: January 13, 1967

23A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23B. DATE: 1/16/67
23C. NAME of CEMETERY or CREMATORY: WOODLAWN
23D. LOCATION (City, town, or county) (State): WOODLAWN, BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
24B. NAME OF REGISTRAR: Robert E. Fasbaum
24C. FUNERAL DIRECTOR: H. V. MEARS & SON ADDRESS: 805 N. CALVERT ST.

VS 151-REV. 1/1/65

K-560

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0492 Registered No. 67 0492

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): THOMAS KINNEAR

2. DATE AND HOUR OF DEATH: 1/14/67 6:15 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MD GEN HOSPITAL BALTO., Md 21201
48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-34
D. STREET ADDRESS (If rural, give location): 6116 BELAIR Rd.

5. SEX: MALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 01/12/88
9. AGE (In years last birthday): ~~78~~ 79
If Under 1 Yr. Months: Days: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor
10B. KIND OF BUSINESS OR INDUSTRY: Rail road
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ANDREW KINNEAR
14. MOTHER'S MAIDEN NAME: FANNIE THOMPSON

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 717-07-6811
17. INFORMANT: Kenneth R Koskinen MD.
ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
1B. 4221
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — 1 month
DUE TO
(B) congestive heart failure — 2 yrs.
DUE TO
(C) ASCVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(2) foot-gangrene.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 01/05/67 19 to 01/14 19 67, that (I) (we) last saw the deceased alive on 01/14 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Kenneth R Koskinen M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/14/67
23C. PHYSICIAN'S NAME (Type): KENNETH R. KOSKINEN. M.D.
23D. ADDRESS: Md Gen Hospital Balto., Md.

24A. BURIAL CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 1-17-67
24C. NAME of CEMETERY or CREMATORY: PARKWOOD
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: [illegible]
25C. FUNERAL DIRECTOR: Chas. F. Evans + Son
ADDRESS: 8802 Harford Rd

VS 150-REV. 1/1/65

E-236

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0493 Registered No. 67 0493

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Doris A. Easter

2. DATE AND HOUR OF DEATH: Jan. 15, 1967 | 8 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 00

13 W. Barney St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 23-03

D. STREET ADDRESS (If rural, give location): 13 W. Barney St.

5. SEX: Female

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: June 19, 1909

9. AGE (In years last birthday): 57

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph Gannon

14. MOTHER'S MAIDEN NAME: Catherine Mc Laughlin

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John A. Easter ADDRESS: 13 W. Barney St.

MEDICAL CERTIFICATION

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Carcinomatosis 199.2 — Since 11/25/66

DUE TO

(B) Adenocarcinoma with metastasis to liver, lung & bones. — 1 yr

DUE TO

(C) Primary Site unknown.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 15 Nov. 1966

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: See (18)

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/25 19 66 to — 19 , that (I) (we) last saw the deceased alive on 11/28 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: E. S. Ellison, M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/16/67

23C. PHYSICIAN'S NAME (Type): E. S. Ellison M.D.

23D. ADDRESS: 107 E. West St. #30

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1 19 1967

24C. NAME of CEMETERY or CREMATORY: Glen Haven

24D. LOCATION (City, town, or county) (State): Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Geo. E. Fadigan

25C. FUNERAL DIRECTOR: O. McCully

ADDRESS: 130 E. Fort Ave

VS 150-REV. 1/1/65

B-623

BIRTH NO. 67 0494

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0494

1. NAME OF DECEASED (Type or Print): BROCATO, VINCENT JR.

2. DATE AND HOUR OF DEATH: 14 JANUARY 1967 3 05 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Balto. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 53-00

D. STREET ADDRESS (If rural, give location): 409 ROANOKE DRIVE

5. SEX: MALE

6. RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): WIDOWED

8. DATE OF BIRTH: 06-06 97

9. AGE (In years last birthday): 69

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. POST OFFICE

10B. KIND OF BUSINESS OR INDUSTRY: RET.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? AMERICAN

13. FATHER'S NAME: VINCENT BROCATO SR.

14. MOTHER'S MAIDEN NAME: GRACE M. ~~MARY~~ GEPPI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: HOSPITAL RECORDS

ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCT — INTERVAL BETWEEN ONSET AND DEATH: 6 HOURS

DUE TO

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(C) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE — 1 YEAR or more

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 13 Jan 1967 to 14 Jan 1967, that (I) (we) last saw the deceased alive on 14 Jan 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Fridjofur Bjornsson M.D.

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED: 1-14 1967

23C. PHYSICIAN'S NAME (Type): FRIDTJOFUR BJORNSSON M.D.

23D. ADDRESS: UNION MEMORIAL HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 1/17/67

24C. NAME of CEMETERY or CREMATORY: NEW CATHEDRAL

24D. LOCATION (City, town, or county) (State): BALTO. MD.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert B. Fairbanks

25C. FUNERAL DIRECTOR: E.S. MALNABB

ADDRESS: 301 FREDERICK 21228

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-200 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0495 — Registered No. 67 0495

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): WAKE, ELSIE MARY

2. DATE AND HOUR OF DEATH: JANUARY 13, 1966 — 12:10P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND — FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

40

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND — B. COUNTY: 21226 — A.A. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE — 52-00
D. STREET ADDRESS (If rural, give location): 8227 FORT SMALLWOOD ROAD

5. SEX: FEMALE
6. RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 7/10/91
9. AGE (In years last birthday): 75 — If Under 1 Yr. Months: Days: — If Under 24 Hrs. Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? UDA
13. FATHER'S NAME: FRANK CREINER (DEC'D)
14. MOTHER'S MAIDEN NAME: MAY (BROWN) CREINER
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: — ADDRESS:

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — 1B. 586X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SURGICAL COMPLICATIONS — DUE TO 2 DYS POST OP

(B) IMMEDIATE CAUSE OF DEATH NOT KNOWN — DUE TO

(C) POSSIBILITY OF MYOCARDIAL INFARCTION OR PULMONARY EMBOLISM.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCVD

19A. DATE OF OPERATION: —
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED — White At Work ☐ — Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from DECEMBER 30, 19 66 to JANUARY 13, 19 67, that (X) (we) last saw the deceased alive on JANUARY 13, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE: [signature] — M.D. — Attending Phys. ☐ — Med. Director ☐ — Staff Phys. ☒
23B. DATE SIGNED: JANUARY 13, 1967
23C. PHYSICIAN'S NAME (Type): GEORGE E. PATRICK — M.D.
23D. ADDRESS: ST. AGNES HOSPITAL

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 1/16/67
24C. NAME of CEMETERY or CREMATORY:
24D. LOCATION (City, town, or county) (State): URBANA, VIRGINIA

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fairbanks M.D.
25C. FUNERAL DIRECTOR: McCully F.H. — ADDRESS: 237 PATAPSCO AVENUE

VS 150-REV. 1/1/65

operation: 1/10/66 - Cholecystectomy - Information via phone - St Agnes Hosp.

5-425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X

BIRTH NO. 67 0496 Registered No. 67 0496

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): ALBERT B. SLACUM

2. DATE AND HOUR OF DEATH: 1/12/67 4 38 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital Balto. Md. 8

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND B. COUNTY: Dorchester Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): CAMBRIDGE 59-13

D. STREET ADDRESS (If rural, give location): OAKLEY ST.

5. SEX: Male

6. RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Married

8. DATE OF BIRTH: 7/14/05

9. AGE (In years last birthday): 61

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES A. SLACUM

14. MOTHER'S MAIDEN NAME: IOLIA STEPHENS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS

ADDRESS

MEDICAL CERTIFICATION

I

1B. 162.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) PNEUMONIA

DUE TO OBSTRUCTIVE ~~[illegible]~~

(B) OAT CELL CARCINOMA OF LUNG & MEDIASTINA

DUE TO

(C) METASTASIS

INTERVAL BETWEEN ONSET AND DEATH

7 Days

3 Months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/28/66

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: CA LUNG

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/21 19 66 to 1/12 19 66, that (I) (we) last saw the deceased alive on 1/12 19 66 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Irvin M. Sopher M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/12/66

23C. PHYSICIAN'S NAME (Type): IRVIN M. SOPHER M.D.

23D. ADDRESS: University Hosp. Balto. Md

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan. 15, 1967

24C. NAME of CEMETERY or CREMATORY: Green Lawn Cemetery

24D. LOCATION (City, town, or county) (State): Cambridge, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Fisher

25C. FUNERAL DIRECTOR: Kenneth B. Thomas

ADDRESS: Cambridge, Md.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-4 110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0497 Registered No. 67 0497

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): JOSEPH MALOFF

2. DATE AND HOUR OF DEATH: 1/14/67 12:15 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL 35

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTIMORE 27-18
D. STREET ADDRESS (If rural, give location): 5436 NELSON AVE.

5. SEX: MALE
6. RACE: CAUCASIAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): MARRIED
8. DATE OF BIRTH: 4/15/1889
9. AGE (In years last birthday): 77
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLOTHING CUTTER
10B. KIND OF BUSINESS OR INDUSTRY: CLOTHING
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY MALOFF
14. MOTHER'S MAIDEN NAME: IDA (NOT KNOWN)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-10-6888
17. INFORMANT: ADMISSION HISTORY ADDRESS:

MEDICAL CERTIFICATION

18. 609XT-E904.8

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH
(A) GRAM NEGATIVE SEPSIS (PROBABLE) — 3-4 DAYS
DUE TO
(B) URINARY TRACT INFECTION — 15 DAYS
DUE TO
(C) URINARY RETENTION (CHRONIC) — CHRONIC

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ~~WOUND INFECTION (SURGICAL)~~ — ~~7 DAYS~~ ad

CERTIFICATION APPROVED BY: CHIEF OF VITAL STATISTICS, MEDICAL EXAMINER. 1/17/67

19A. DATE OF OPERATION: 12/29/66
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED: FRACTURED LEFT HIP
20A. AUTOPSY? (Yes or No): NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that I (this hospital) attended the deceased from 12/28/66 19 to 1/14 1967, that (I) (we) last saw the deceased alive on 1/14 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE: Jerry B. Rogers M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒
23B. DATE SIGNED: 1/14/67
23C. PHYSICIAN'S NAME (Type): JERRY B. ROGERS M.D.
23D. ADDRESS: CHURCH HOME & HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/15/67
24C. NAME of CEMETERY or CREMATORY: Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Kelley, M.D.
25C. FUNERAL DIRECTOR: Sylvan S. Lewis & Son
ADDRESS: 3319 Olympia Ave

VS 150-REV. 1/1/65 N 8210

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BIRTH NO. 67 0498 Registered No. 67 0498

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Brozer, Samuel

2. DATE AND HOUR OF DEATH: 8:15 AM 1/16/67 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 33 The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 232 N. Chester St.

5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months / Days	If Under 24 Hrs. Hours / Min.
Male	White	Married	3/15/91	75		

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESMAN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): RUSSIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Max

14. MOTHER'S MAIDEN NAME: Fannie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-01-0571

17. INFORMANT: Mrs. Lillian Brozer ADDRESS: 232 N. Chester St.

MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. 260X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — 1 wk.

DUE TO

(B) ASHD & Atrial fib. — 1958

DUE TO

(C) Diabetes Mellitus — 1960

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/14 1967 to 1/16 1967, that (I) (we) last saw the deceased alive on 1/16 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: C H Brown, III M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☑

23B. DATE SIGNED: 1/16/67

23C. PHYSICIAN'S NAME (Type): C. H. Brown, III M.D.

23D. ADDRESS: The Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1/17/67

24C. NAME of CEMETERY or CREMATORY: United Hebrew Cemetery Corp.

24D. LOCATION (City, town, or county) (State): Rosedale

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Fabry, MD

25C. FUNERAL DIRECTOR: Jack Lewis, Inc. ADDRESS: 2100 Eutaw Place

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620

BIRTH NO. 67 0499

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0499

1. NAME OF DECEASED (Type or Print): PERCY, EMMA Sue

2. DATE AND HOUR OF DEATH: 1/13/67 4:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Windsor Rest Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY: 2612 W. FRANKLIN ST. Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township): BALTO. 20-02

D. STREET ADDRESS (If rural, give location): 2612 W. FRANKLIN ST.

5. SEX: F

6. RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Widowed

8. DATE OF BIRTH: 12/21/1885

9. AGE (In years last birthday): 81

If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Smith

14. MOTHER'S MAIDEN NAME: Catherine Marsh

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Edith C. Bennett, ADDRESS: 305 Westowne Rd. 21229

MEDICAL CERTIFICATION

18. 420.1 I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

(A) Coronary Thrombosis

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20A. AUTOPSY? (Yes or No): NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9/21 1966 to 1/13/67 19..., that (I) (we) last saw the deceased alive on 1/13/67 19..., and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: [signature] M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐

23B. DATE SIGNED: 1/13/67

23C. PHYSICIAN'S NAME (Type): Harris Donaline M.D.

23D. ADDRESS: 930 Whitehall St. Balt. Md.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 1-16-1967

24C. NAME of CEMETERY or CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967

25B. NAME OF REGISTRAR: Robert E. Farley M.D.

25C. FUNERAL DIRECTOR: Howard H. Hubbard, ADDRESS: 4107 Wilkens Ave. 21229

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-6010

BIRTH NO. 67 0500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 0500

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print): Brooks Mary Estelle

2. DATE AND HOUR OF DEATH: Jan. 12, 1967 - 7:15 AM M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lincoln Nursing Home 27 N. Carey Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside city limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 2143 Druid Hill Ave

2143 Druid Hill Ave H-03

5. SEX: Female
6. RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: Aug. 27 1893
9. AGE (In years last birthday): 73
If Under 1 Yr. Months | Days | If Under 24 Hrs. Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charles Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James H. Brooks
14. MOTHER'S MAIDEN NAME: Nancy Mahoney

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-34-6125
17. INFORMANT: Hattie R. Richardson Same
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 0
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20A. AUTOPSY? (Yes or No):
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED: While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from ..... 19 ..... to ..... 19 ....., that (I) (we) last saw the deceased alive on ..... 19 ..... and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE: Harris Sonnenline M.D.
M.D. Attending Phys. ☑ Med. Director ☐ Staff Phys. ☐
23B. DATE SIGNED:
23C. PHYSICIAN'S NAME (Type): Harris Sonnenline M.D.
23D. ADDRESS: 930 Whitelock St.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-17-67
24C. NAME of CEMETERY or CREMATORY: Met. Meth Church Cemetery
24D. LOCATION (City, town, or county) (State): Charles Co. Md.

25A. DATE REC'D BY HEALTH DEPT.: JAN 17 1967
25B. NAME OF REGISTRAR: Robert E. Fortune
25C. FUNERAL DIRECTOR: Barnes & Matthews F.H. Richard J. Kay
ADDRESS: 3615-14 St. N.W. Washington, D.C.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.